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Volume 55
Number 1

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TABLE OF CONTENTS

	Page
The President's Page	21
Charitable, Educational, and Scientific Foundation of the State Medical Society	22
Blue Shield and Blue Cross for Physicians—A Membership Service	23
Disability Program Aids 259 Physicians	24
Malpractice and the Physician	25
The Unlicensed Physician	33
Physician, Patient, and the Professional Secret	34
Physicians' Exemption from Jury Duty	37
Discarding Case Records and X-Rays	38
The Confidential Nature of Hospital Case Records	39
Schedule of Programs of the "March of Medicine"	40
Fee Splitting	41
Physicians and the Workmen's Compensation Act	42
Liquor Prescriptions	48
Physicians and Child Placement	49
Identification by Blood Test	50
Sterilization	50
Legal Aspects of Abortions	59
Postmortem Examination	60
Death Certificates	61
Sale of Contraceptives and Abortifacients	62
Employers of Four or More Subject to Unemployment Insurance Tax	62
Your Deadlines and Other "Musts"	63
Epileptics and the State Motor Vehicle Department	64
Chemical Tests for Intoxication	64
University Hospitals	65
Physicians Advised on Substitution of Silver Nitrate	66
Instructions for the Use of Wisconsin State Laboratory of Hygiene	67
Officers of State Boards and Commissions	68
Benefit Programs of the W.I.A.A.	71
Rehabilitation Services in Wisconsin	76
TB in State and County Hospitals for the Mentally Ill	79
Information, Please	80
State Medical Society of Wisconsin	
Officers and Councilors	82
Standing Committees for 1955–1956	83
Map Indicating Location of Councilor Districts	85
Roster of Members	87
Charter Law of Medical Societies in Wisconsin	100
Constitution and By-Laws	101
These Guides May Help You	108
Principles of Medical Ethics of the American Medical Association	111
Past Presidents of the State Medical Society	118
Recipients of the Council Award	121
Facts about Wisconsin Physicians Service	123
The Journal Bookshelf	124
Physicians' Exchange	133
Index to Advertisers	134
Officers of Sections of the State Medical Society	136
List of Officers and Scheduled Meetings of County Medical Societies	137

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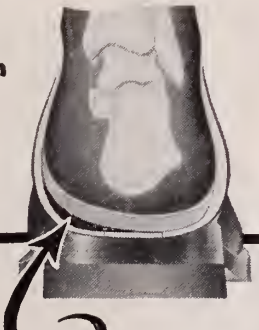

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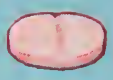
NEW  1 mg. *pink* tablet | 5 mg. tablet

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On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

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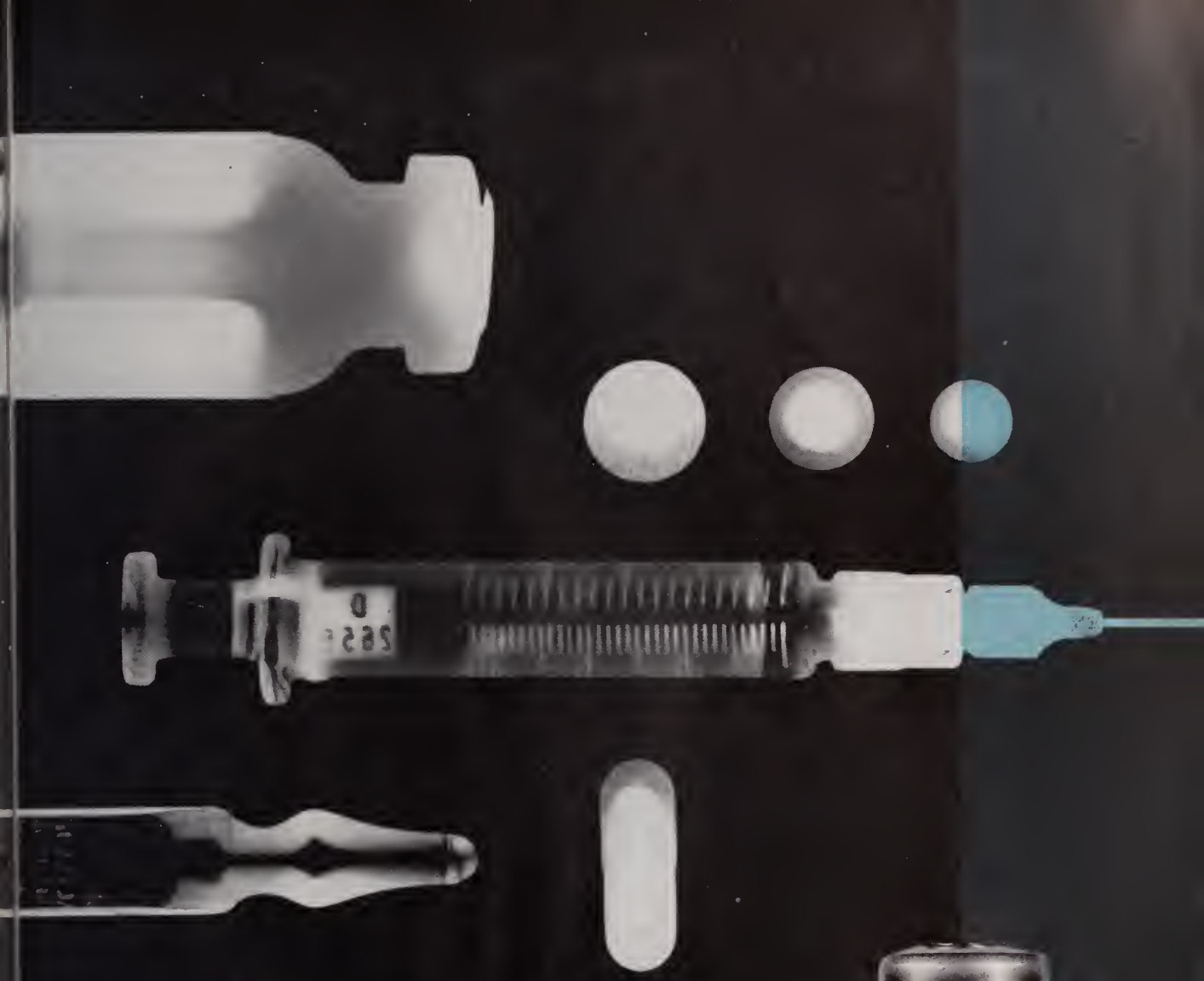

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1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.

2. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agr.cultural Handbook No. 8, 1950.

3. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.

4. Cheldelin, V.H., and Williams, R.J.: Studies on the Vitamin Content of Tissues, II, Houston, Texas, University of Texas Publication No. 4237, 1942.

5. Schweigert, B.S.; Nielsen, E.; McIntire, J.N., and Elvehjem, C.A.: Biotin Content of Meat and Meat Products, J. Nutrition 26:65 (July) 1943.

6. Scheid, H.E., and Schweigert, B.S.: The Vitamin B_{12} Content of Meat, Annual Report, An Outline of Research During the Fiscal Year 1953-54, Chicago, American Meat Institute Foundation, Bull. 22, 1955.

7. Estimated on basis of protein content of meats. Sherman H.C.: Food Products, ed. 4, New York, The Macmillan Company, 1948 p. 155.

8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

TABLE I	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg. magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

TABLE II — Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

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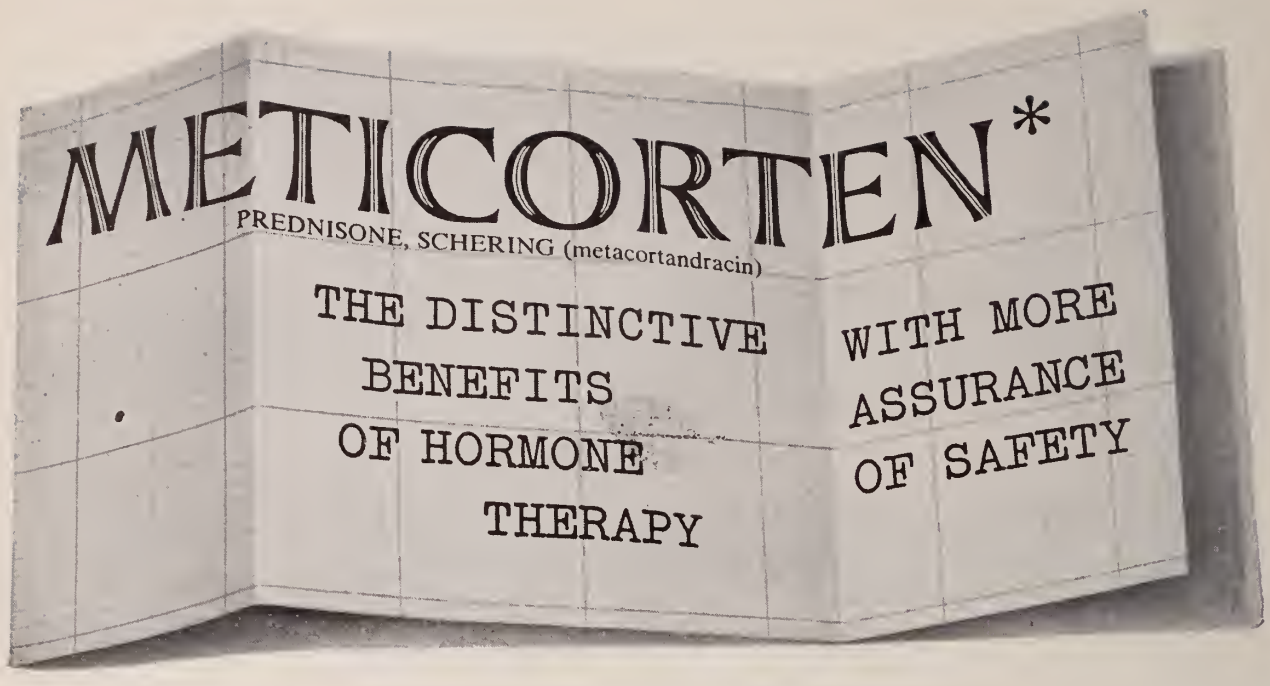

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(1) Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955. (2) Gray, J. W., and Merrick, E. Z.: J. Am. Geriat. Soc. *3*:337, 1955. (3) Boland, E. W.: California Med. *82*:65, 1955. (4) Dordick, J. R., and Gluck, E. J.: J.A.M.A. *158*:166, 1955. (5) Margolis, H. M., and others: J.A.M.A. *158*:454, 1955. (6) Hollander, J. L.: Philadelphia Med. *50*:1357, 1955. (7) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Dis. Chest *27*:515, 1955. (8) Arbesman, C. E., and Ehrenreich, R. J.: J. Allergy *26*:189, 1955. (9) Skaggs, J. T.; Bernstein, J., and Cooke, R. A.: J. Allergy *26*:201, 1955. (10) Schwartz, E.: J. Allergy *26*:206, 1955. (11) Nelson, C. T.: J. Invest. Dermat. *24*:377, 1955. (12) Robinson, H. M., Jr.: J.A.M.A. *158*:473, 1955. (13) Herzog, H. L., and others: Science *121*:176, 1955. (14) Perlman, P. L., and Tolksdorf, S.: Fed. Proc. *14*:377, 1955. (15) King, J. H., and Weimer, J. R.: Experimental and clinical studies on Meticorten (prednisone) and Meticortelone (prednisolone) in ophthalmology, A.M.A. Arch. Ophth., in press. (16) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Clinical and physiological studies on the use of metacortandracin in respiratory disease. II. Pulmonary emphysema and pulmonary fibrosis, Dis. Chest, to be published. (17) Dordick, J. R.,and Gluck, E. J.: Preliminary clinical trials with prednisone (Meticorten) in systemic lupus erythematosus, A.M.A. Arch. Dermat. & Syph., in press. (18) Goldman, L.; Flatt, R., and Baskett, J.: Assay technics for local anti-inflammatory activity in the skin of man with prednisone (Meticorten) and prednisolone (Meticortelone), J. Invest. Dermat., in press.

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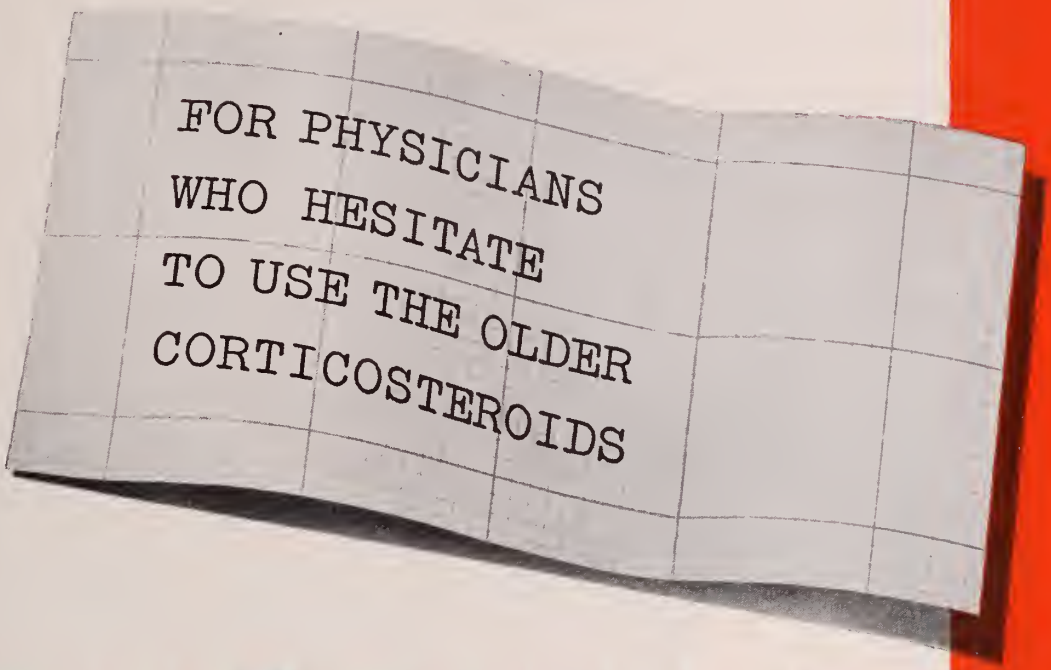

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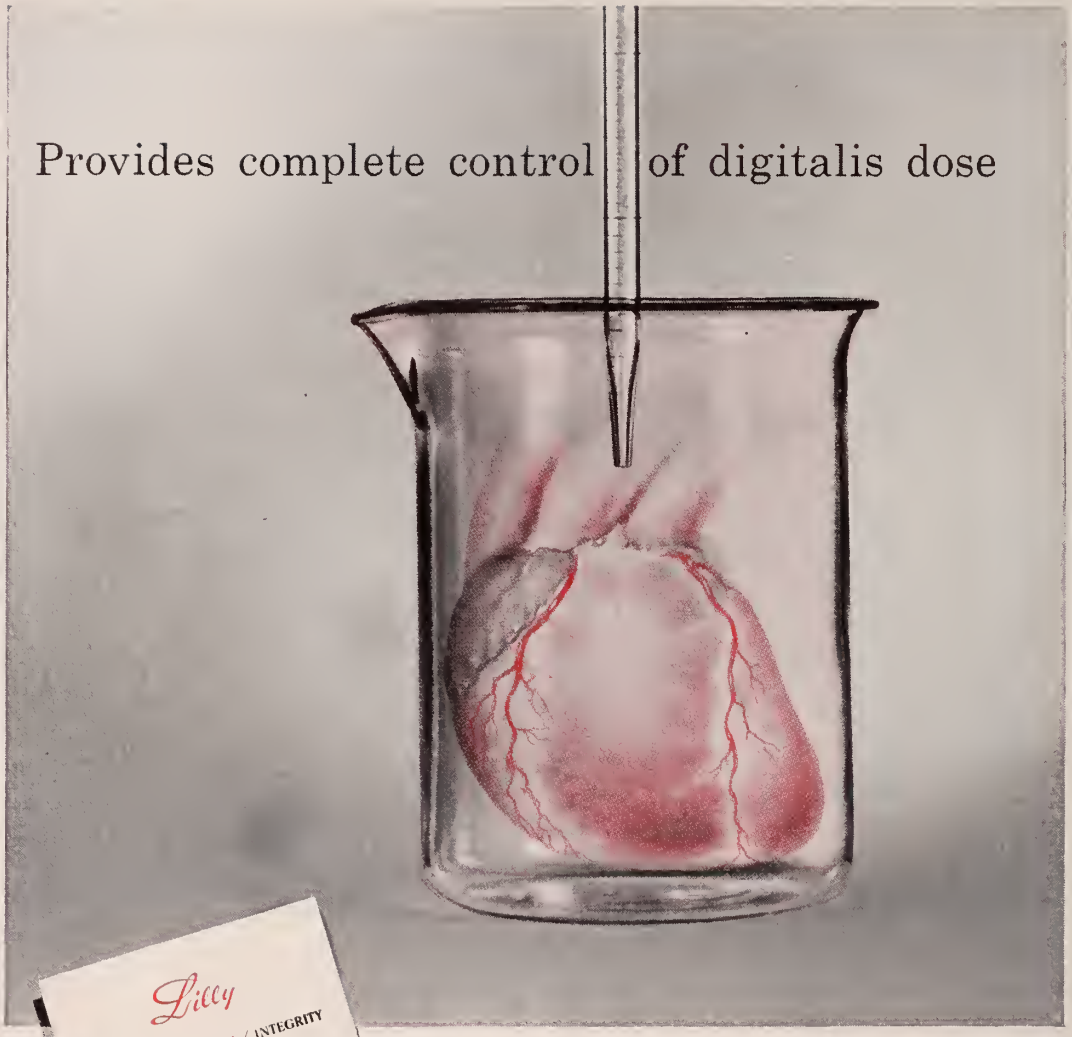

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(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1956
D. H. Witte, Milwaukee, 1956
William D. Stovall, Madison, 1957
Joseph C. Griffith, Milwaukee, 1956

ALTERNATES

L. O. Simenstad, Osceola, 1956
Ervin L. Bernhart, Milwaukee, 1956
R. E. Galasinski, Milwaukee, 1956
C. E. Koepp, Marinette, 1957

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. . . . THE PRESIDENT'S PAGE . . . .

Foreign Physicians Again

ONLY a few years ago a great public furor developed over the inability of a "displaced" physician from Europe to obtain a license to practice medicine in Wisconsin. While public interest raged hot and heavy, the problem was not unanticipated by the profession. The State Medical Society had been concerned about the possibilities of just such difficulties for several years, and without adequate legislation the State Board of Medical Examiners simply had to take it on the chin.

The sensationalism of the case may have served some good purpose, however, by providing added impetus to a suggestion of the Medical Society that some kind of approval system be set up for foreign medical schools comparable to that for American and Canadian schools. The American Medical Association and the Association of American Medical Colleges got to work on the idea and early in 1950 published a list of 47 foreign medical schools whose graduates they recommended for consideration for licensure on the same basis as graduates of approved schools in this country. In part, the program has been successful; but the difficulties of continuous on-the-spot inspection are proving almost insuperable.

I recently learned from the State Board of Medical Examiners that at least 120 foreign graduates are applying for licensure in Wisconsin every year. And this appears to be only the beginning. It is known that there are nearly 1,800 American G.I.'s studying medicine in European schools. The first of these are beginning to return to their homeland, and Wisconsin can expect its share. Many have attended schools which are not on the so-called approved list. How can they be evaluated?

One can sympathize with the Board of Medical Examiners in its task. Who can verify the accuracy of credentials from foreign schools? Who can testify to the adequacy of basic science training? Who can produce evidence of satisfactory clinical training and experience? Is it fair to license foreign graduates according to lesser standards than those required of American graduates?

The Society and the Board of Medical Examiners are jointly considering proposals to deal with the problem. A 12-man screening board has been suggested to determine whether any foreign graduate is eligible to take basic science and licensing examinations in Wisconsin. Another idea suggests at least one year of prelicensing study for each candidate from a foreign school. Reports, both good and bad, are coming from other states which have tried these systems.

The problem is not an easy one. Physicians should be giving serious thought to how to meet it. The return to Wisconsin of G.I.'s with diplomas from foreign schools is bound to produce another public hubbub unless some method can be found to deal with the situation.

Erwin L. Bernhart M.D.

Charitable, Educational, and Scientific Foundation of the State Medical Society

FOR some time the leadership of the Society has been aware that a number of its members, as well as friends of medicine, were or could be interested in making grants or contributions to projects within the province of the medical profession. Such grants, if made to the Society, would not be deductible by the givers for income tax purposes, a fact which has very likely been a deterrent to such gifts.

In 1951 the Society established a trust called the Student Loan Fund, designed to acquire funds for loans to needy medical students. This was a tangible effort to solve an important problem through a closely affiliated organization. Contributions and grants received by that Fund from organization to November, 1955, totaled $17,445. During that same period, 22 medical students received loans from the Fund; some of these are now in the process of being repaid.

However, it became increasingly evident that it would be desirable to establish a single organization which could receive contributions for charitable, educational, and scientific purposes from physicians and others and administer them in accordance with the intention of the givers or the best judgment of the management of such a body. This type of organization is commonly referred to as a "foundation." When it is organized in accordance with state and federal income tax laws, the organization is exempt from such taxation. Gifts or grants made to such an organization are deductible by the givers, whether they be individuals or corporations. Dual exemption thus makes a foundation attractive in these days of high taxes.

At its May, 1954, meeting, the Council authorized the study and preliminary organization of such a foundation. Experience has demonstrated that the overwhelming majority of similar organizations take that form, because their continuation is not so directly dependent upon individuals, as in the case of a trust or unincorporated association. Further, there is a tendency on the part of givers to prefer that the object of their gifts be a corporation; and they attach an increased stability and likelihood of survival to an incorporated foundation.

Therefore, the Council recommended the incorporation of a Foundation, governed by a Board of Trustees composed of (1) the Council of the Society and (2) an elected representative from each component county society. It recommended that the officers and members of the Executive Committee of the Foundation be trustees who are also members of the Council. Terms of the county society members are for three years and so staggered that approximately one-third of the members are elected each year, thereby helping assure stability.

The Wisconsin Statutes on nonstock corporations no longer require members, and it is possible to operate entirely with a governing board. Since no Society member has vested rights in the Foundation in the sense that a practicing physician does in his medical society or his hospital staff, it was believed preferable to dispense with membership as part of the structure of the Foundation.

While this means a board of approximately 70 members, the officers and Executive Committee both come from the Council and this is a small enough number to work efficiently in governing the Foundation. It seems basically important that there be a representative in each county society who will be informed in the affairs of the Foundation and who can handle inquiries, contributors, candidates for loans or grants, and other matters.

The Foundation should be thought of as an additional arm under direct management of the governing body of the Society itself.

The potentialities of the Foundation are almost unlimited. Many unsolved scientific, educational, and economic questions have grown out of or are related to the practice of medicine today. They are the subject of much speculation and much writing for which there often exists no adequate factual basis. Many statements are made in government circles which represent either inadequate studies or confused conclusions. Medicine has a direct obligation to the people, as well as to itself, to determine or review facts underlying such problems and, where necessary, to state, restate, or correct conclusions. The very freedom of medical science may be dependent upon the manner in which these problems are studied and presented to the public. All too often the public accepts what appears to be an answer but what, in fact, is not an answer. The medical profession should study these problems and propose solutions, as a matter of qualification, public interest, and legitimate self-interest.

Recently, a committee of the Medical Society has made a study of the causes of maternal deaths in the State of Wisconsin. It is now making a study of the closely associated subject of neonatal deaths. All such studies cost money. If several of them were to be conducted at one time, they could impose a heavy drain on the current dues or the reserves of the Society.

The advisability of enlargement of funds for loans to medical students would seem obvious. Much more complex would be the development of mechanisms for making grants to disabled physicians who might otherwise be public charges in part or in whole. Other professions have developed such mechanisms,

and these clearly fall within the category of direct charity.

The medical profession, or certain of its members, might be interested in having special studies made in fields for which no other grants were available. Medical men have commented that a few of the fields and problems of medicine have relatively generous funds accessible for their study at present, while others have nothing. The Foundation may be able to correct this inequality in some measure.

The above could be greatly expanded, but it is believed that it furnishes enough examples to demonstrate the potential breadth of the interests and functions of the Foundation.

Sources of Funds

Under authority of the House of Delegates, all active members of the State Medical Society over the age of 35 and in active practice were asked to contribute voluntarily $10 or more during the fiscal year 1955–1956. At the time of preparation of this article, 538 physicians had responded to the appeal; and while some contributions were less than the amount requested, a number were in substantial excess. The total received at this time was $6,180. Several of the contributions were in commemoration of the passing of friends.

Most of the funds so far received have been loaned to seven medical students recommended by their deans as in need and deserving of help from the fund. Some donations have been specified for aid to medical schools, and the wishes of the donors are being carried out.

The Foundation is looking both to physicians and the public for contributions. The physician will be solicited annually, but may make his contribution in a number of ways: by a yearly donation at the time of solicitation or through a will, a commemorative gift, or a carefully directed and earmarked offering.

Equally important is the opportunity for the physician to advise and encourage laymen—patients and friends—who are considering memorial gifts to direct those gifts and bequests to the State Medical Society Foundation. The physician can assure the potential donor that gifts may be earmarked for special purposes, but that unspecified gifts will always be used for worthy educational, charitable, or research purposes in the medical field.

Every practicing physician recognizes the unquestionable need for timely aid to his needy kin of the profession. The public joins the physician in the realization that the amazing progress of man makes imperative the advancement of learning in scientific and economic fields if satisfactory solutions are to be found for a variety of medical and interrelated social problems.

Individual effort seldom has the opportunity to become significantly effective or to be given proper credit for a contribution to society. Now, the State Medical Society Foundation offers physicians and the public an unprecedented opportunity to give of their substance to deserving causes of medical interest with assurance that their contributions will be productively utilized and that posterity will be cognizant of their acts.

Blue Shield and Blue Cross for Physicians

A Membership Service

A GROWING number of physicians are participating in the Blue Shield and Blue Cross group protection made possible by membership in the State Medical Society. This group plan is now in its second year.

New members of the Society are offered the opportunity to obtain Blue Shield and Blue Cross protection at the time they apply for membership. Each new member receives a letter from the Society office announcing the various membership services. The letter includes a Blue Shield–Blue Cross application, which must be returned within 30 days for the physician to be accepted for coverage without regard to the condition of his health. Coverage is available for all "active members" of the Society and their families at group rates.

Physicians who do not take advantage of the group offer at the time they become members of the Society and those who are older members of the Society may obtain group Blue Shield and Blue Cross coverage for themselves and their families during the annual enrollment of physicians in November of each year. Applications received during the annual enrollment period will be processed so that coverage becomes effective on December 1 of each year. The annual enrollment opens the coverage to all active members without regard to health conditions.

Of course, physicians and their families may enroll any time for the nongroup type of Blue Shield and Blue Cross coverage. However, this type of enrollment requires a health questionnaire. Those who enroll for the nongroup coverage may transfer their protection upon request at the time of the annual enrollment.

Physicians who are covered through regular groups such as clinics or hospitals are advised to continue their existing coverage rather than transfer to the State Medical Society group. In their own group they have the opportunity for the same coverage as is offered through the State Medical Society group, and their membership in the local group may be needed to maintain minimum enrollment requirements for the rest of that group.

Physicians have a choice of Blue Shield protection—either the "A" or "B" Schedule of Benefits for surgery, maternity, anesthesia, x-ray, and 70-day, in-hospital medical care benefits.

A choice of Blue Cross protection is also available —the 70-day comprehensive program paying 100 per cent of semiprivate hospital room charges and 100 per cent of certain hospital extras, or the co-insurance contract under which the physician assumes 25 per cent of the first $400 of hospital charges normally covered by the contract.

The Blue Cross office bills physicians semi-annually for all Blue Shield and Blue Cross premiums.

Any questions concerning the protection, and requests for information about applications for coverage should be sent to the State Medical Society office.

Disability Program Aids 259 Physicians

ONE out of every seven members of the State Medical Society protected by the Group Disability Insurance Program was disabled during the past year and became eligible for disability benefits.

This startling incidence of disability among physicians was one of the major factors prompting the State Medical Society to offer group disability protection as a membership service. The Provident Life and Accident Insurance Company of Chattanooga was selected to underwrite the coverage; and since it assumed responsibility for the protection in August, 1950, it has provided more than $875,000 in benefits of all types to Wisconsin physicians.

Any doubts as to the desirability of group disability protection should be dispelled by the fact that, during the 12-month period ending November 1, 1955, the Provident Company received notices of claims from 259 doctors enrolled in the Society program. These were notices of either partial or total disability and did not involve any specific loss such as accidental death and dismemberment. On the basis of 1,750 member physicians covered by the program, these figures show that one out of every 6.8 covered physicians (14.8%) was disabled during that year.

This insurance is available to members of the Society in the active practice of medicine who are less than 70 years of age. Benefits for insured members are available through age 74. The basic program provides for total disability payments of $75 per week for total disability resulting from an accident or sickness. Partial disability benefits are $37.50 per week. There are also substantial payments for accidental death and dismemberment. A physician will be allowed $10 per day while confined to a hospital and, in addition, up to $100 to cover hospital expenses other than for room and board.

An optional benefit of an additional $25 of weekly disability payments is offered to members in good health between the ages of 34 and 60, provided these members do not carry more than $150 weekly indemnity under plans made available to them by reason of membership in other professional organizations.

One of the great advantages of a group program as opposed to individual insurance is that eligible members may subscribe without submitting the usual health questionnaire, provided that their application is made when they become eligible. New members of the Society who are under age 32 may apply within one year and the members over 32 within 6 months, without consideration of present physical condition or past medical history. Group insurance also provides a considerable premium advantage.

A physician who does not purchase this program at the time it is first offered to him may apply at any time, but the company may accept or reject such application on the basis of a health statement which must be provided at the physician's expense.

The Provident Plan is the only group disability insurance program officially sponsored by the State Medical Society. Similar policies available to the medical profession through other state societies and the national specialist organizations have been examined critically, and so far as it is known, the Wisconsin program continues to offer the most in income protection benefits per dollar of premium charged.

Additional information on this subject is available through the Society offices.

All benefits outlined above are subject to the terms of the policy.

Malpractice and the Physician*

By LOUIS J. REGAN, M. D., LL. B.

THE incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. If this alarming situation were evidence that the medical profession was becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all malpractice suits filed are without merit; more than half of them involve physicians who are above the median of their respective groups in skill, experience, and professional standing. The search for a solution to this problem demands an understanding of what actually constitutes malpractice, an analysis of the causes of malpractice claims, and a universal knowledge among physicians as to the positive steps which may be taken to decrease both the relatively few justified claims and the preponderantly greater number of unjustified claims.

Any Physician May Be Sued for Malpractice

The bringing of a malpractice action does not even suggest that the claim has merit; for any patient may bring such an action against any physician who has attended him professionally. Nevertheless, the practitioner who is the target of the accusation is damaged by the mere filing of the action. Accordingly, it is necessary that every physician understand what constitutes malpractice under the law.

What Constitutes Malpractice Under the Law?

The law requires that a physician who undertakes to diagnose or to treat a patient must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist, he must meet the standards of practice of the specialist in the designated field of practice. These legal interpretations of his duty are not changed if the professional services are rendered gratuitously. It follows, then, that no malpractice charge is justifiable unless the physician's service to the patient does not meet the requirements of good medical practice; unless in the diagnosis or treatment of his patient, the physician omits to do something he should do or does something he should not do in terms of accepted standards of practice. The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases.

This definition of standards needs further clarification; for medicine is not an exact science, and not all patients who are given medical treatment get well. Many are left with some disability or deformity. There are few conditions in which there is available a sole, specific, universally utilized remedy or procedure. There is frequently a great latitude for honest difference of opinion, and often the attending physician must exercise his best judgment in deciding which of the several methods to adopt. In certain circumstances, the physician's acts or omissions may be so unseemly and shocking as to be generally recognized as reprehensible and supportive of legal liability. On the other hand, complications or untoward and unexpected results are not uncommon, and the mere fact that a patient is not cured or does not progress favorably does not suggest culpable ignorance or negligence on the part of the medical attendant.

Under Law, What Skill and Care Has the Patient the Right to Expect?

In the absence of evidence to the contrary, the law presumes that a physician has exercised the ordinary skill and care required of him in treating his patient. He is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality. He may make a mistake in diagnosis or be guilty of an error of judgment; he may use medicines or methods of treatment different from those which some of his colleagues would have used; he may obtain a bad result instead of a satisfactory one; but no one of these things is sufficient to fasten upon him the charge of malpractice. Actionable malpractice consists in doing something that should not be done or in omitting to do something that should be done.

Malpractice Suits Lessen Public's Confidence in Medical Profession

It is of primary importance, of course, that every physician familiarize himself with his legal interpretation of what does and what does not constitute malpractice. But that is only the first part of the control of the malpractice contagion; for experience has taught us that the most meticulous attention to the dictates of good medical practice is not sufficient to ward off unjust claims and that no physician, regardless of his excellence, is immune. The

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* Reprinted, with permission, from the Journal of the American Medical Association, September 2, 1951. In a more recent, but less comprehensive, article on the same subject, Doctor Regan says, "the situation continues to grow worse." See *The Journal of the American Medical Association*, December 4, 1954, page 1317, "Malpractice, an Occupational Hazard."

The footnotes, except for those enclosed in brackets, are Doctor Regan's own. Bracketed footnotes indicate insertions made in editing the article for republication.

misunderstanding, indeed the ill will, which has been engendered by the great number of unjust malpractice suits has tended to break down the public's confidence in the medical profession. This situation has important and far-reaching implications for both the public and the medical profession; for the public interest is adversely affected when the physician in caring for his patient is forced to give thought, time, and energy to safeguarding himself against the possibility of an unjust malpractice claim. The public should be informed of the facts of this problem, for in the long run, it is the public—in the persons of individual patients—whose well being is being jeopardized. There is no relationship outside the family which is so personal and intimate as that of physician and patient, no relationship in which the character, integrity, and conscience of one party are so important to the well being of the other. The overwhelming majority of physicians faithfully and unselfishly meet the demands and obligations of their calling; and the majority of patients do not unjustly file malpractice suits. The acts of the ignorant, the greedy, the callous few—among either patients or physicians—must not be permitted to destroy the merited esteem in which the profession as a whole is held.

How Much Shall the Physician Tell His Patient?

As a basic step in improving the situation, the physician must realize that at all times he is obligated to act with the utmost good faith toward his patient. Thus, if he knows that he can not accomplish a cure or that the treatment adopted will probably be of no benefit, he is duty bound to advise his patient of these facts.[18a] It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient. Such completely open handling of a case would do much to improve the physician-patient relationship and to remove the possibility of unjust malpractice actions. However, there are other unavoidable and even psychological factors in the practice of medicine which must also be considered carefully in this respect.

Factors That Promote Malpractice Suits

If physicians were always able to obtain perfect results there would be, of course, no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Whether or not the uncured patient brings an action is often determined by his feeling toward the physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not so likely to sue for malpractice—even when bad results ensue. Malpractice suits more often arise if the patient is resentful of some fancied or actual affront, if he believes that he has not been sufficiently closely attended, or—above all—if some third person raises a doubt in his mind as to the propriety of the treatment. In regard to this last point, it would be sheer folly to assume that the "third person" is always—or even most often—a layman who is uninformed about the facts of the case. Regrettably, many of these people are physicians who are also uninformed about the details and facts but who precipitate unjustifiable suits by criticising directly or by implication the work of physicians who have cared for particular cases.

Another potential danger to the physician-patient relationship arises from the physician's lack of attention to certain elements of patient psychology as factors in malpractice causation. Although the patient is sick or injured when he comes to his physician, he nevertheless visualizes himself as he was prior to becoming sick—with his body structures intact. Thus, unless the physician understands this viewpoint and prepares the patient properly, the patient with a fracture, for example, is likely to compare the final result with the part prior to injury, not with the injured member as presented to the physician. As another example of patient psychology, the average patient is not disposed to understand an error in diagnosis or the failure to make an early diagnosis. Or again, the unwarned patient is not happy with the surface tissue changes which are some times associated with deep x-ray therapy.

An analysis of malpractice claims reveals the significant fact that they arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates a suit against his physician. It is obvious, then, that from the very first contact—indeed, especially with the very first contact—the physician should do everything within his power to develop an honest, frank, and psychologically sound relationship with his patient.

How Physicians May Safeguard Themselves Against Malpractice Suits

The foregoing discussion has analyzed what malpractice is and what can be done in the physician's conduct to avoid real malpractice or to forestall the filing of an unjust claim. But it would be completely unrealistic to assume that any course of conduct on the part of the physician would prevent his being unjustly sued for malpractice. Good medical practice in itself is not enough; the physician must be able to defend his actions by proof of what he has

[18a A physician runs a serious risk if, by persisting in unsuccessful treatment, he keeps his patient from going elsewhere. The physician may be held liable for damages to compensate the patient for being deprived of successful treatment available from another physician. The same principle applies if the physician, by leading the patient erroneously to believe that he is not ill, discourages him from seeking treatment elsewhere.]

done. He must not only know his legal duty to his patient, but he must fulfill it. He must know and take advantage of every measure to protect himself against the unjustified claim of malpractice. Under present circumstances, it is absolutely foolhardy for any physician to be ignorant of or careless of malpractice prophylaxis. He must take positive actions carefully based upon his legal responsibilities and liabilities.

To begin with, a physician is not legally obligated to undertake the care of any patient. But from the time he assumes the responsibility until he is discharged or withdraws from the case, he must give—or be sure that there is given—the care and treatment required by the condition of the patient. Before a physician may, without legal liability, withdraw from a case he must give reasonable notice of his intention and allow the patient reasonable opportunity to fill his place.

By notice or special contract, the physician may limit the service he is to render. He may agree to treat the patient only at a certain place, or for a limited time, or for certain conditions. On the other hand, he may increase his obligation by expressly agreeing or warranting that he will effect a particular result; in this circumstance, he will be liable on his contract or warranty if he fails to fulfill the agreement. A physician is not an insurer of results unless he makes himself one by his special promise.

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse, to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be construed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

Expert Testimony and Res Ipsa Loquitur

Generally, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur*[1] in a case gives rise to an inference of negligence on the part of the defendant, and relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalities, (4) roentgen radiation injuries, generally limited to cases wherein the roentgen ray is being used diagnostically, (5) infection through the use of an unsterilized needle or instrument, and (6) injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

A Good Case Record is a Valuable Safeguard

The importance of good medical case records, as a factor in malpractice prophylaxis can not be overestimated. A good medical case record should contain a history[2] of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as the basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will reflect (by means of progress notes) a sequential history of the case, its course, complications, and sequelae and, thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case are also a part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course.[3]

Unwarranted Professional Criticisms Promote Malpractice Suits

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for mal-

[1] *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

[2] It is important to indicate the source of the medical history (from the patient, member of family, etc.).

[3] There is a legal presumption that a letter mailed has been received by the addressee; but there is no presumption that a letter has been mailed.

practice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticise destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient.

Other Preventive Precautions

The importance of tact can hardly be overemphasized. It should be manifest especially in the handling of the patient and the patient's family; in the avoidance of fee disputes and unwise efforts and methods in the collection of fees (considering the provisions of the statute of limitations); in the avoidance of overoptimistic prognoses and especially of any promise constituting a guarantee of a particular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting (or which might be construed as) an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; and in the securing of legal advice before making any statement in regard to a malpractice claim or suit.

Liability for Acts of Others

In addition to being responsible for his own acts and omissions, a physician encounters, in his everyday practice, instances in which he may also be responsible for the negligent acts and omissions of others. Thus, he is responsible for the acts of his assistants and employees, for their negligence occurring during the course of their employment. Where doctors practice as partners, each partner is liable not only for his own acts and those of his partner, but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligent acts of the other which he has observed or which in the exercise of ordinary diligence he should have observed.

The attending physician is generally not liable for the negligence of an interne, a nurse, or other hospital employee. He is, however, responsible for the acts of the hospital personnel in so far as they are carried out under his immediate supervision and control. Thus, the operating surgeon and not the hospital is held liable for any negligence of operating room attendants during the performance of surgery.

Consent for Operations, Treatment and Autopsies

Consent for operation must always be secured. Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, the physician should invariably require a witnessed consent in writing. If the patient is a minor (that is, a person under the age of twenty-one) consent is to be obtained from parent or guardian.[4] If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required.

When an operation is made compulsory by law (such as vaccination or sterilization[5]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform without consent such operation as good surgical practice demands.[6]

If sterility is likely to result from the surgery which is contemplated, explanation of that probability should be made and a signed authorization obtained from both spouses. It should be borne in mind that it is hazardous to sterilize any person except upon a positive medical indication. Further, there should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken.

The individual physician must secure consent to perform a postmortem examination. This, too, should be in writing[7] and sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

The trend of the cases in recent years indicates that it is extremely unwise to pursue a course of treatment in itself hazardous or capable of producing harmful effect without securing a written statement from the patient, or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the special treatment.

Failure to Use Recognized Diagnostic Aids

There are a large number of malpractice actions in the law reports which may be classified under the general heading of "Insufficient Treatment Cases." In every field of medical practice there are cases illustrating "insufficient care": the failure to make

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[4] Statutory exception: In California a female of the age of 18 or more who is or has been married is an adult for the purpose of this consent.

[5] Under Eugenic Sterilization Statutes.

[6] 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.

[7] In California, and several other states, it is criminally illegal for any person to perform an autopsy without having first obtained the written authorization of the coroner or other authorized public officer or of the person who has the right of disposition of the body.

a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up; failure to make a complete diagnosis or overlooking a reasonably determinable condition; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); the failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts, etc., etc.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. Whenever a fracture is present which was not diagnosed and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standard of good practice.[8] Whenever a bad result, deformity or limitation of motion occurs, the defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Whenever a patient refuses to have an x-ray made, the physician should fortify himself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice action may be brought.

The statute of limitations provides the period of time after which specified actions may not be brought. The time provided varies greatly in the several states. A physician should wisely inform himself of the situation in his own state.

Obligations to Patients

To summarize, the physician who would understand his legal obligations, responsibilities, and duties to his patient, must constantly bear in mind the following fundamental obligations:

1. The physician must possess the degree of skill commonly possessed by other reputable practitioners in the same field of practice.

2. He must exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

3. He must keep abreast of progress and follow good practice, common practice, in diagnosis and treatment; he must not experiment.

4. He must not neglect or abandon his patient; he must proceed diligently, without unnecessary delay.

5. He must give his patient sufficient attention and must utilize the indicated diagnostic aids.

6. He must find or anticipate any condition reasonably determinable or reasonably likely to develop.

7. He must obtain legal consent to operate and to perform an autopsy.

8. He must give proper instructions (that is, instructions consistent with the standard of practice) for the care of the patient in his absence, and for the protection of those coming in contact with the patient.

9. He must fulfil the terms of a special contract if he makes one.

The foregoing directions for reducing and avoiding the instigation of malpractice suits will not, of course, guarantee that a physician will not be sued unjustly; for already malpractice may be regarded as a contagious disease of the social body. There are several major reasons for this condition, but two are paramount: (1) the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious"; and (2) such suits are difficult to defend, and the knowledge of how best to conduct such a defense is not sufficiently widespread. The inter-relationship of these two points will be obvious; for each successful defense of an unjust suit will serve as a discouragement to the filing of others. But the second of these causes of high malpractice incidence—the difficulty of conducting a defense—is dangerously enlarged by many physicians themselves. Large numbers of medical men are naive enough to believe that their patients would never file such suits and that no precautions need be taken; and yet such precautions are the only assurance of the best possible defense in the event of a suit. The most vulnerable physicians are those who know that they are maintaining at least an average standard of practice and who are therefore (and blindly) assuming that they will not be sued. This discussion is concerned with *unjust* claims; no doctor who is actually guilty of malpractice should be allowed to go free of penalty. Meritorious claims should be settled out of court—preferably before a suit has been filed.

Prompt Attention Should Be Given to Claims

Another too frequent hindrance to an adequate defense is delay in the investigation of claims; such delay is highly disadvantageous to the preparation of a defense. As a final word of warning that the physician may need every available precaution, one must consider the conditions under which most cases are heard. They are tried before juries made up of lay persons, and it is a truism that no one can say what a jury will do. This is particularly true of malpractice cases, for certainly lay jurors can not be expected to understand complex medical facts. How does a jury arrive at a decision when two expert witnesses testify that the defendant's conduct of the case did not meet the required standard, and two others declare that what the defendant did was consistent with the usual and ordinary practice in the community?

[8] "The failure to make use of x-ray as an aid to diagnosis in cases of fracture amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing in the community and the court, in absence of expert testimony, may take judicial notice of such fact." Agnew v. City of Los Angeles (Cal.) 218 Pac. (2d) 66.

To physicians who have had little or no experience with the law and to lawyers who have little or no medical knowledge, the problem of adequately defending the unjust malpractice case seems insurmountable. And it is true that far too many such cases have been lost simply through poor defense. This is an aspect of the problem which needs a great deal more attention, particularly in areas which have become virtual "hot beds" of non-meritorious malpractice claims. At all times and to all physicians, there should be available expert advice on problems relating to the physician-patient relationship.[9] Whenever a threat is made against a physician, a carefully prepared procedure should be put into effect. Unjustified claims should be contested as thoroughly as possible. In such cases, it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course simply serves as an encouragement to others whose claims are not justified. This shortsighted view is largely responsible for the rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

Be Slow to Compromise

It is a great temptation to a doctor to rid himself of a nuisance claim by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often true, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim.

A List of "Commandments" in Malpractice Prevention

In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments":

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician should keep "ideal" medical records in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from overoptimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

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[9] Regan, L. J.: Doctor and Patient and the Law, St. Louis, The C. V. Mosby Company, 1949, chap. 20.

11. The physician should have some knowledge of the statute of limitations and of its significance.[10]

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

Conclusions

There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to correct it.

The public should be informed as to (1) what constitutes malpractice, (2) how really few cases of actual malpractice occur, and (3) the major degree of responsibility which the individual has in the maintenance of his own health.

Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

Addenda

I. Consent to Operation

Place _____

Date _____

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me_____

_____

_____

and to do any other procedure that (their) (his) judgment may dictate during the above operation. 2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____ I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.

3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

A.M. Signed _____

Hour _____P.M. Witness _____

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.[1]

Date _____ Signed _____

A.M. Witness _____

Hour _____

P.M.

1. Cross out paragraphs not applicable to particular case.

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[10] In Wisconsin, the statutes of limitations of greatest importance to the physician are Section 330.19, subsections (3) and (5) thereof, and Section 330.27. By virtue of Section 330.19 (5), the patient, in order to claim damages against his physician for malpractice, must either bring suit within two years of the alleged event or else bring suit within six years after having given, within two years, a formal notice of his intent to sue. Section 330.27 makes the same rule apply also in those situations where the patient is sued by the physician, and where, were it not for the statutes of limitations, the patient might assert malpractice as ground for a counterclaim for damages against the physician.

Ordinarily, suit for unpaid salary, wages, or other compensation for personal services must be brought within two years; but fees for professional services are not so limited. See Section 330.21 (5). Instead, under Section 330.19 (3), the physician has six years in which to bring suit for fees.

Since a patient who is slow to pay his bills might be especially quick to respond to suit by a counterclaim based on a groundless charge of malpractice, the physician does well to wait for two years before commencing an action for his fees. The patient may then still argue that the treatment was so far below professional standards as to be non-compensable, but at least he will be barred from basing a malpractice claim on the treatment given.]

II. Consent to Operation upon Minor

Place _____

Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ____, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anesthetic or anesthetics in this case.[2]

2. A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

A.M. Signed _____( )

Hour _____P.M. _____

Witness _____

III. Consent to Observers and/or Photographs and/or Televising

In the interests of science and the furtherance of medicine, I, the undersigned, do hereby consent to and authorize _____ Hospital, and the Operating or Treating Surgeon and such doctors as may be assisting him, to examine and operate or treat me in the presence of other than the usual surgical staff.

I further authorize and consent to the taking of photographs and such subsequent use thercof as may be deemed advisable by said hospital and/or doctor, or doctors.

I further authorize and consent to the televising of any operative or other procedure performed or carried out upon me.

Dated _____ Signed _____

Witness _____ Witness _____

IV. Patient Fails to Carry Out Advice

Note. When a patient neglects or fails to carry out advice, it is desirable to have the facts established in writing. It may be wiser to withdraw from the case (See VII). This is a matter for the judgment of the physician in the particular case.

SAMPLES[3]

3. Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Place _____

Date _____

A.

Name of Patient
Address
Dear Mr. _____:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

B.

Dear Mrs. _____:

Upon the history you gave me and my findings on examination, both of this date, I am not able, as I told you at the time of your visit, to rule out pregnancy as the cause of the vaginal bleeding of which you complain.

You have told me that you will not submit to a pregnancy test. I again now advise you of its desirability. I hope you will come in tomorrow morning prepared, as I instructed you, to have the test made. If you continue to refuse to submit to this test, it will be necessary to have a consultant see you tomorrow, if I am to continue to advise you.

Yours very truly,

C.

Dear Mrs. _____:

When, in response to your call today, I saw your husband at your home, I told you my opinion was that he is very seriously ill with pneumonia, and that he should be immediately hospitalized. You refused to permit me to have him removed to the hospital. I told you that I am willing to do the best I can for him under the circumstances, but that he could be better cared for and he would be safer, with less likelihood of complication, in the hospital.

Your husband's condition is such that the matter cannot be discussed with him, so I hope that you will now, after giving the matter more thought, authorize his removal to the hospital.

Yours very truly,

D.

Dear Mrs. _____:

You brought your seven-year old boy in today for me to see. He has a deep, penetrating wound on the sole of his foot, apparently resulting from his stepping on a nail. You thought that it had been received in a neighboring stable.

I advised you that the boy should immediately be given an injection of tetanus antitoxin. You refused to permit me to administer this to him, stating that you had heard of two children who had severe reactions following such prophylactic treatment.

I told you that I would make a preliminary test which would warn us of the likelihood of severe reaction, but that I could not guarantee that result or any result. You reiterated your refusal.

I cannot give the boy this treatment, or any treatment, without your consent. I urgently recommend that you permit me, or some other physician of your choice, to administer a preventive dose of tetanus antitoxin to your boy without further delay.

Yours very truly,

V. Patient Fails to Keep Appointment

SAMPLES[4]

4. When a patient fails to keep an appointment, or discontinues treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Place _____

Date _____

A.

Name
Address
Dear Mr. _____:

My records indicate that you failed to keep your appointment of _____ (date), and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention is, in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

Yours very truly,

B.

Dear Mrs. _____:

You have not returned, as arranged, since, at your request, I examined you on last Friday.

The history you gave of "spotting" between periods over the last several months, and my findings on examination, which I related to you, are of such significance that, as I endeavored to impress upon you when I made an appointment for you to return with your husband, I must urge upon you the advisability of having immediate medical attention.

If you do not wish to return to me, you should consult another physician at once.

Yours very truly,

C.

Dear Mrs. _____:

You failed, again, today to appear in accordance with your appointment at the Radiologist's office so that a check-up x-ray could be made of your fractured wrist.

I have previously urged upon you the necessity of having your cooperation to improve the likelihood of a favorable result.

You should not be heard to complain of the end result, if it is not satisfactory, when you refuse or neglect to follow the advice of your physician.

I now request that you appear at my office at ten o'clock tomorrow morning. I am arranging to have x-rays made at that time and to have a specialist in orthopedic surgery see your arm.

Yours very truly,

VI. Patient Discharges Physician From Case[5]

5. If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Dear Mr. and Mrs.----------:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

VII. Physician Withdraws From Case

Note. A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. If the fact, whether a physician did withdraw from professional attendance upon a natient. became an issue in the case the burden of proof falls upon the physician. For this reason, it is desirable that written evidence be available.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

SAMPLES[6]

6. Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Place ----------

Date ----------

A.

Name
Address
Dear Mr. ----------:

You have repeatedly failed to follow my advice and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly.

B.

Dear Mr. ----------.

You consulted me this afternoon in connection with an injury to your foot and ankle. At that time, upon your refusal to have x-rays made of the injured area, I advised you that I could not undertake to render professional service to you.

So that there may be no misunderstanding, I am confirming these facts in writing.

Yours very truly.

C.

Dear Mrs. ----------:

As I told you this morning, I cannot longer continue to be professionally responsible for the care of your little boy. This decision is necessitated by the fact that you have repeatedly refused to permit me to make the detailed and thorough study of his condition which I regard as indicated and vital.

Please secure other medical attention at once. In the meantime, and for a reasonable time, I shall remain available, at your request, to render any routine or emergency service that may be required.

I shall, of course, be glad to offer to Tommy's new physician the knowledge of his case which I have been permitted to acquire.

Yours very truly,

D.

Dear Mrs. ----------:

You failed to keep your appointment this week.

At the time you received your injection last week a portion of the needle broke off in your tissues. You were at once advised of this accident. As I told you, after preliminary search, I was unable to recover the broken piece without anesthesia and incision, and recommended that localization studies be made prior to undertaking definitive search.

I again recommend that procedure and will make arrangements at your request and responsibility.

Yours very truly.

THE UNLICENSED PHYSICIAN

Problems arise when a physician licensed to practice in another state comes to Wisconsin and enters association here with other doctors before he has obtained a license, either permanent or temporary,* for practice in Wisconsin.

Perhaps he has the best of intentions to refrain from practice until his Wisconsin license is issued. Nevertheless, especially if he has been long in practice, he may be found, probably as a matter of habit, doing many an act unintentionally and unwittingly that might constitute for him illegal practice, or at least subject him to criticism, or worse.

The best advice, therefore, is for the physician to postpone contact with patients until his Wisconsin licensure is complete.

The next best advice is for him to be circumspect. Let him issue no prescriptions over his own signature. Let him see patients only in consultation with his associates who are already licensed. Let him act the part not of a physician, but at most of an apprentice or a physician's deputy.

* For details on Wisconsin licensure, permanent or temporary, see Section 147.15 of the Wisconsin Statutes as affected by Chapter 581 of the Session Laws, 1955.

Physician, Patient, and the Professional Secret

THE respect which the physician has, as a matter of course, for his patient's privacy is formalized in one of the principles of medical ethics:

> "Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state." *(Principles of Medical Ethics of American Medical Association, Chapter 2, Section 2.)*

Legal Status of the Professional Secret

The duty, thus imposed by ethics, is enforced by law. A Wisconsin statute, Section 147.20 (1) (d), includes the wilful betrayal of a professional secret as a ground for revocation of a physician's license.

Both the ethical principle and the law recognize that the patient's right of privacy is less than absolute and that there are times when the physician's duty is to reveal, rather than to conceal, what he has learned about the patient in the course of professional treatment. The right and correlative duty are not grounded on sentiment; they are based on considerations of reason. Fair play will cause every person to hesitate before publishing what another has told him in confidence. But the physician is not "every person"; nor is the patient just "any other." The physician-patient relationship is a special one, and the rights and duties surrounding professional secrets are special rights and duties that arise from the special quality of that relationship.

Every person's desire to protect secrets is subject to at least one important restraint. When called to testify before a court, he is sworn to tell the "whole truth" as well as "nothing but the truth." The ordinary rule subjects him to punishment for contempt of court (which is to say, contempt for the symbol of the law itself) if he refuses to answer a question properly put to him. And this is as it should be. If courts are to decide issues by applying the law to the facts, the courts must be empowered to demand revelation of the facts. The court's power to insist on revelation can reasonably be curbed only when the reason for concealment is more worthy of respect than the business of the court itself.

Generally speaking, the business before courts is weighty business. Only exceptionally does our law concede greater weight to other matters. The law's high regard for the person's ordinary right to freedom is shown in the constitutional privilege to refuse to testify in a way that might tend to incriminate the witness himself. Its respect for the integrity of the home has put limits on the testimony that might be demanded from spouse against spouse. Its recognition of the social stability that the practice of religion encourages has led it to hold inviolate the seal of the confessional. The value the law places on the well-being of the human body is shown in the privileged status it gives to communications made by a patient to his physician. In Wisconsin, this privilege is set out in Section 325.21 of the Statutes:

> *Wisconsin Statutes*, §325.21. "Communications to doctors. No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide, (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition."

The Patient's Privilege and the Physician's Duty

The foregoing statute appears in the chapter on "Witnesses and Oral Testimony." If it were repealed, it would make no change in the physician's legal as well as ethical duty to keep secret what he has learned from or about his patient in the course of professional treatment. Section 147.20 would continue to put the physician's license in jeopardy if he should violate his duty. Actually, it is Section 147.20 that is the primary concern of the physician. Section 325.21 is rather the concern of the patient himself or of his attorney when the patient becomes or is about to become involved in litigation. The physician, guided by Section 147.20, is well advised never to speak about his patient's affairs (1) unless he has the express consent of the patient himself or of someone identified by competent legal authority as empowered to consent for him, or (2) unless he is commanded to speak by the presiding judge of a court. This advice borrows from Section 325.21 for aid in interpreting Section 147.20, but the advice would be just as sound tomorrow, even if Section 325.21 were repealed today.

Precautions for the Physician

Certain points in the above advice deserve special emphasis. If it is consent that the physician relies on as his authority for revealing a patient's secrets, let the physician be sure that it is *express*. He will more easily determine whether or not it is express if the patient puts it in writing; and if the patient affixes his signature to the writing, the physician will be better able to persuade the State Medical

Grievance Committee or a court that he had spoken with consent, if trouble should later arise. Whenever possible, then, let the physician demand a signed consent and then let him heed any limits with which the writing circumscribes the consent.

If the physician relies on consent given by another on behalf of the patient, let the physician be sure not only that the consent is express, but also that the person giving the consent is able to consent for the patient. In the most common situations, the physician can be sure without seeking further assurance from his attorney. For example, when the patient is still a minor child, a parent, as natural guardian, is capable of giving the consent; but if the parents are dead, let the physician be sure that the guardian who offers a consent for the child has been legally appointed as guardian. If the patient has died, the physician may rely on letters testamentary or letters of administration as sufficient identification for an executor or administrator of the patient's estate who might validly proffer express consent for the revelation of professional secrets. But the physician should not rely, without preliminary investigation, on a consent proffered simply by a member of the family of a deceased or incapacitated patient. Such a person may, or may not, be legally competent to consent.

Some Problems for the Physician's Attorney

The physician's attorney, in determining whether or not a person is competent to waive secrecy for a patient, will note first of all that Section 325.21 of the Wisconsin Statutes permits a substitute for the patient's personal consent only if the patient himself is dead or disabled. The disability meant is, of course, not such disability as the physician diagnoses, but *legal* disability. It is for this reason that a parent can consent for a perfectly healthy child. In the case of, for example, the mentally incompetent adult patient, the investigation should show that the incompetence has been legally determined and declared before substituted consent should be relied on. The physician then can rely on consent from the patient's legal guardian.

The next thing that the physician's attorney will note in Section 325.21 is that, given the prerequisite death or disability, then there are only three categories of persons who qualify to give substituted consent. They are: (1) the patient's personal representative; (2) any other person authorized to sue for the patient's personal injury; and (3) any beneficiary of an insurance policy on the life, health, or physical condition of the patient.

The third of these categories is self-explanatory, but the physician's attorney would want to check whether the insurance policy was in force and to examine the policy and its endorsements for a sure identification of the beneficiary. The first two of the categories might become somewhat more involved. "Personal representative" was defined by statute in Wisconsin for the first time by the 1953 legislature. It is defined for a limited context (as used in Chapters 310 through 324) only, and whether the meaning there given would carry over, in a troublesome case, into Section 325.21 remains for the courts to decide. The cautious attorney would, for the present, take the narrow view. As for the second category, the physician's attorney would again be cautious. He would inquire into the relationship between the patient and the person offering a substituted consent and would then check both the common law and the statutes to determine whether the substitute had authority to sue for the patient's personal injury. He would also want to know, for example, whether the injury had been suffered in an industrial accident. These are clearly matters for the physician's attorney, not for the physician himself, to study.

Legal Scope of the Professional Secret

Scope of the Patient's Privilege

The privilege statute, Section 325.21, though not so important to the physician as Section 147.20 (1), which puts a legal sanction on his ethical duty to guard his patient's secrets, is an aid both to the physician and his attorney in better understanding the physician's duty. The consent clause of Section 325.21 emphasizes the fact that to be secretive is the patient's privilege, not the physician's. Other clauses of the section still further clarify the law's view of the professional secret.

First of all, Section 325.21 suggests that not everything related by patient to physician receives the protection of the law, but only what is "necessary to enable him professionally to serve such patient." Obviously, many a remark volunteered by a garrulous patient would be outside the scope of the privilege, but this does not mean that all the information, to be privileged, must turn out to be actually useful in diagnosis and treatment. The physician, in order to evoke the facts that he needs, may judge it necessary to encourage free and easy talk. Disclosures made under such circumstances should be privileged, for, in the judgment of the physician (who is the best judge of such matters), they are necessary to enable the physician to serve his patient professionally. They would probably qualify as professional secrets.

Secondly, Section 325.21 indicates what reasons are more important than the reason for which the law undertakes to protect the secret revealed by patient to physician. It has already been suggested that the reason for the patient's privilege is the law's regard for the integrity of the human body. The law wants the sick to take the steps necessary for the restoration of health, and to have the will to keep themselves well. The law recognizes that often, as a practical matter, the physician cannot care for the patient intelligently unless he is informed of many a fact that would do the patient no credit in the community—or, at least, that a sensitive patient would not want to have published. To encourage the patient, for his health's sake, to approach his physi-

cian with confidence, the law lets the patient know that, except for reasons more compelling than the patient's health, his secrets will be safe. Only to prevent miscarriage of justice in homicide trials, to permit the facts to be disclosed in lunacy inquiries, or to protect the physician himself against charges for malpractice, will the law permit its own courts to draw the patient's secrets from his physician without the patient's consent. The physician will be prudent to assume that the law will be no more generous to him than to its own courts if he should, outside of court, consider revealing a professional secret.

In the third place, Section 325.21, in its terms, restricts only the physician from testifying. And Section 325.21, since it creates an exception to the general rule that courts are entitled to the whole truth from witnesses, is construed narrowly by the courts. That is to say, the terms of the statute are not expanded to include nurses, hospital technicians, internes, unlicensed internes, and the like who regularly give assistance to the physician. The patient may not claim his privilege with respect to any of his secrets they have acquired. The physician, therefore, does a favor to his patient when he permits his assistants to obtain only such private information about his patient as they must know in order to render their assistance efficiently.

Fourthly, Section 325.21 has no application except where there was a genuine physician-patient relationship. Information obtained by a physician in the case of an autopsy is not privileged. Neither is information obtained by a physician in the course of an examination made for purposes other than the diagnosis and treatment of the examinee. If a physician who is also a health officer acquires information while making an examination in his capacity of health officer, there is no privilege. The same principle applies where a physician examines an applicant for life insurance. However, the fact that this principle governs in determining whether information is exempt from the rule that a witness in court must tell the "whole truth" does not necessarily mean that the physician is exempt from a legal duty under Section 147.20 (1) (d) to refrain from wilful disclosures.

Finally, not only do the terms of the statute limit the scope of the privilege it creates, but the courts, by judicial construction, keep the privilege narrowly confined. They declare the statute to be "in derogation of the common law" and appropriate for strict, as opposed to liberal, construction. This is understandable, for any expansion of the privilege is necessarily a restriction of the courts' own traditional freedom of inquiry into factual issues in litigation.

A recent case before a trial court involved a motorist who had received medical treatment for a severe cut suffered in a collision. The physician had already testified that observations as to his patient's sobriety were unnecessary for the treatment administered. Therefore he was required to testify, over objection, that he had observed his patient to be drunk. This ruling by the trial court has not been passed upon by the Wisconsin Supreme Court, and is doubtful as legal precedent, but it does illustrate judicial reluctance to apply the privilege if a way can be found to rule against it. However, the judicial restraint thus put upon the scope of the patient's privilege, though it tends to free the lips of the physician in court, does not necessarily lessen the scope of his duty of silence in other situations.

Scope of the Physician's Duty

Section 325.21, the privilege statute, does not tell the whole story about the physician's legal duty to protect professional secrets under Section 147.20 (1) (d). Actually the physician will often have the duty to reveal information under circumstances not hinted at under Section 325.21. Whatever the circumstance, however, the prudent physician will ask for a written signed consent before making any revelation.

Among the situations in which the physician properly discloses matters otherwise to be kept secret are: (1) those in which the patient has made a claim under the Workmen's Compensation Act; (2) those in which the physician has discovered the presence of diseases which he is by law required to report to public authorities; and (3) those in which overriding ethical considerations make disclosure necessary.

Under the Workmen's Compensation Act, an employee making a claim for an occupational disease or for an injury suffered in connection with his employment obviously is in no position to require the physician who treated him to withhold his findings from the Industrial Commission. In personal injury cases in general this same principle is often applied. Under Section 269.52 (2) of the Wisconsin Statutes, a court may require a party claiming damages to undergo a physical examination by a court-designated physician, and to submit his x-ray photographs and hospital records to the defending party for study, or forego his right to use those x-rays or records on his own behalf at trial. In the Industrial Commission's application of this principle, though the privilege as such is inoperative, some deference is paid to it. The Commission has said:

> "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

It is equally a matter of practical necessity, where communicable disease puts the public health in peril, that such disease, when detected by a physician in the course of treating a patient, be reported to the proper authorities. Included in this category are, of course, venereal diseases. The law also requires physicians to report cases of occupational disease; congenital deformities in newly born infants; and cancer, carcinoma, sarcoma, or other malignant growths.

Practical necessity will often also move a physician to disclose information on his own initiative to persons not specifically authorized by statute to receive it. Sometimes, says Section 2 of Chapter 2 of the Principles of Medical Ethics of the American Medical Association, "a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances." Take, for example, the situation in which the psychiatrist, prior to a judicial determination of the patient's insanity, must, according to the dictates of good common sense, warn the patient's family, or even his associates or neighbors, of possible physical danger to them.

Good sense and ethics similarly will solve the problem presented occasionally upon premarital examination. The physician may find that while the applicant is free from venereal disease, he does have some physicial or mental disability or abnormality which would render him unfit for marriage or would make impossible the consummation of a satisfactory marriage relationship. The question then arises as to the liability of the physician upon disclosure of his findings to the other prospective spouse.

This problem is discussed in an article appearing in *The Ohio State Medical Journal* for November 1941. Believing that the conclusions there drawn are of equal merit in Wisconsin, we reprint here the conclusions both as to (1) the liability of the physician to the examinee, and (2) the liability of the physician to the state.

"A physician, disclosing to the other prospective marital partner disabilities or ailments of an examinee that would endanger the other party to the prospective marriage or that it would make it impossible for the parties to enjoy a happy or satisfactory marriage relationship is subject to no liability to the examinee, either in libel or slander or for disclosing a professional secret within the limitations noted; that is, if he acts in good faith and without malice, and makes no further disclosures than is reasonably necessary under the circumstances. Obviously, the problem is simplified if the same physician examines both parties with the definite understanding that findings and observations, if at all material to the prospective relationship, shall be made known to the other party; or if the physician acting with respect to one party only enters into a similar understanding."

"The disclosures under the circumstances here assumed would not constitute the 'wilful betrayal of a professional secret' and would not be the basis for the revocation of the physician's license."

What Is a Wilful Betrayal?

In confidently following the dictates of his professional judgment and his personal sense of ethics when problems on which no definite law has yet been formulated present themselves, the physician may be reasonably sure that he will not run afoul of the sanction with which Section 147.20 (1) (d) protects the patient's privacy. Before the physician's license may be revoked for violation of his legal duty in this matter, he must be found guilty of "wilfully betraying a professional secret." "Wilfully betraying" has not yet been defined by the Wisconsin Supreme Court, but it seems possible that a court might require a showing of some malice on the part of a physician to support such a charge against him. The words "wilful" and "betraying" are strong language, and in the context of ordinary speech they represent a most serious accusation of misconduct. At the very least, it seems likely that a court would find no such flagrant violation unless the physician had fallen clearly—perhaps recklessly—short of the standards of professional judgment in making his disclosures.

PHYSICIANS' EXEMPTION FROM JURY DUTY

Section 255.02 (2) Wis. Stats., 1953, provides exemption of all practicing physicians, surgeons and dentists from serving as jurors. This exemption from jury duty is not a disqualification, however, to act as a juror but is a mere personal privilege which the juror may claim or waive.

Physicians desiring to take advantage of their exemption should appear in court when called to act as jurymen, and should state the cause of their exemption to the presiding judge.

Discarding Case Records and X-Rays

HOW long should you retain your case records after professional services to your patient have ended? When can you safely discard roentgenograms? As records accumulate through the years and storage becomes an increasing problem, these questions become ever more important.

Professional records of physicians are generally considered to be the property of the physician who makes them. There are limitations upon this property right, of course. Professional case records are held by the physician subject to the right in the patient that they be kept confidential. Ethical considerations require that they be made available to a succeeding physician upon the request of the patient.

Subject to those limitations, the physician has a clear property right in his professional records and x-rays. His legal right to destroy them in the absence of statutory restriction follows from his ownership of them. As a matter of professional judgment, however, such records should not be destroyed so long as they have any conceivable value either to the physician or to the patient.

State and federal narcotic laws require physicians to retain narcotic records for specified periods of time, usually two years. Severe penalties, including revocation of narcotic licenses, may be imposed for failure to comply with this requirement. If the Wisconsin physician keeps such records as are prescribed by the State Board of Health, he will meet the requirements prescribed by both the Wisconsin and the federal statutes.

Certainly professional records should be kept as long as they may be of value to the physician or his successor in the treatment of the patient at subsequent times. This is, of course, a moral rather than a legal requirement. It is clear, however, that there are many situations in which a premature destruction of professional records and x-rays could operate as a disservice to the patient and could result in great harm.

Professional records should be retained over the period of time in which the physician's treatment and diagnosis may be a matter of concern to the patient in the prosecution or defense of a legal action or in the establishment of some legal right. The establishment of a service-connected disability in a claim against the Veterans Administration, the determination of mental capacity in a will contest, the evaluation of personal injuries in an automobile accident, the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act, are examples of legal actions in which professional records are of substantial importance to the patient.

The importance of records in the defense of malpractice claims cannot be overemphasized. Professional records and x-rays should be preserved over the period of time necessary to protect the attending physician and the hospital if it is involved, insofar as any claim for malpractice may be concerned. Wisconsin statutes require that one alleging a claim of malpractice must assert that claim either by institution of legal action or by the filing of a formal notice with the physician in a manner prescribed by statute within two years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity.

Even where no suit has been filed or notice given within two years, the patient may still question the value or quality of the professional service as a defense to an action by the physician to collect fees. A collection suit will not then revive a patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be non-compensable. Such a collection action must be commenced within six years and, thus, if the physician considers that it may become necessary to resort to legal action in the collection of his fee, it would be well to retain his professional records for at least that six-year period.

Conclusions

In conclusion, it is believed prudent for the physician and such persons as take care of his office records to follow these policies with regard to retaining patient and related records:

(1) Keep narcotic and other prescriptions at least two years.

(2) Retain other patient records at least six years, so long as there is no known or threatened legal complication such as malpractice or collection suit pending at the end of that period.

(3) Where a suit is brought by a patient, or someone acting for him, against the physician, the physician must preserve all patient records, including x-rays, laboratory reports, and correspondence, until the litigation is concluded, and until the physician's attorney advises that in his professional judgment the time has passed within which other litigation could be brought that might grow out of the first suit. In other words, where there are legal complications, the prudent period for the retention of medical records should be primarily up to the professional judgment of an attorney, not the judgment of the physician or his office staff.

(4) Where suit involving a patient is brought by a physician, the time periods indicated in conclusion 3 should be carefully observed.

(5) Special situations such as the mental incapacity, infancy, or imprisonment of a patient may make the preservation of medical records essential for a longer period than would otherwise be the case. Physicians should rely upon their attorneys in such situations.

The Confidential Nature of Hospital Case Records

A HOSPITAL should guard its case records as a doctor protects his professional secrets, even though no Wisconsin statute expressly so provides.

A decent regard for the patient's privacy dictates attention to this rule. But in Wisconsin legal prudence adds its word, too. There are no precedents for claims by patients against physicians or hospitals for damage to reputations done by inexcusable disclosures, but Wisconsin cases do contain material for strong briefs in support of such claims.[1]

The rule suggesting that hospitals treat their records as confidential is consistent with several of the Opinions of the Wisconsin Attorney General. Section 325.21 of the Wisconsin Statutes, except under special conditions, seals the lips of the physician as a witness in court against revealing professional secrets, but makes no mention of hospitals. Nevertheless, the attorney general has consistently used this "privilege" statute as the criterion for hospitals' duties of secrecy.[2]

The courts have severely limited the privilege statute,[3] at times finding ingenious grounds for admission of medical testimony over objection.[4] But hospitals and physicians should not assume that the contruction of the privilege in the courtroom narrows their private duty. Courts are understandably impatient with obstacles to the disclosure of facts underlying disputes before them for decision. But they have neither similar reasons nor comparable motives for reducing the physician's general duty of secrecy as set out in Section 147.20 (1) (d) of the statutes. No matter what the courts do to the patient's privilege under Section 325.21, the prudent doctor will assume that Section 147.20 (1) (d) will be construed liberally in favor of the patient's secrets.

The prudent hospital administrator will make the same assumption about the hospital's duty to be circumspect about granting access to its case records. In particular, he will not permit information given by the patient to nurses, interns, or others not licensed as physicians to be freely disclosed simply because the Wisconsin Supreme Court has declared such information outside the compass of privileged court testimony.[5]

T. V. McDavitt, Esq., formerly of the legal department of the American Medical Association, writing on "Access to Hospital Records" in the Journal of that association for May 2, 1942, observes that a hospital keeps its records (1) as trustee for patient and attending physician and (2) to preserve evidence of its employees' care and attention. As trustee, the hospital may anticipate trouble if it imprudently reveals information without consent of patient, physician, or both. But if charged with negligence, it may produce its records in its own defense, the same as the physician may under the privilege statute if sued for malpractice.[6]

In the doctor's case, his duty of secrecy is a duty to the patient. The privilege is his patient's, not his own. The hospital's case is much the same. Before opening its records for anyone other than attending physicians or its own employees, the hospital should secure the patient's consent; or if he is a minor, otherwise incompetent, or deceased, the consent should come from a parent, legal guardian, executor, administrator, or insurance beneficiary. For obvious reasons, the consent should be in writing. If it limits the portion of the records to be laid open or the persons to whom access is to be granted, the hospital will honor the restrictions.

But the hospital's case differs from the doctor's since it is custodian of information for him as well as for the patient. Consequently, if there may be medical reason for concealing information from the patient himself, clearance from the physician is indicated before displaying the hospital record.

The duty of secrecy is superseded when the law, by subpoena or other court order, ordinance, or statute, commands the release of information. For example, Sections 140.36 (3), 140.36 (4), and 140.37 of the statutes prescribe special reports by hospitals to the Department of Public Welfare in maternity cases, at the same time, however, establishing safeguards for secrecy. Section 142.03 (3) (c) requires hospitals to report to the Crippled Children Division of the State Department of Public Instruction on crippled children judicially committed for treatment. Numerous statutes require reports on patients receiving care at public expense.

The question occasionally arises whether hospital records may be used to supply data for scientific research. The opening of records for this purpose should not be allowed to invade the patient's privacy. As a general rule, there will be no need for identifying the data with the patient; but if identi-

[1] The argument would run that a doctor's violation of his statutory duty of secrecy is negligence and actionable by the patient, and that the hospital has the same duty at least with respect to its record material provided by attending physicians.

[2] For example, see 35 O.A.G. 116, 37 O.A.G. 282, 39 O.A.G. 346.

[3] *Prudential Insurance Co. v. Kozlowski* (1938) 226 Wis. 641, 276 N. W. 300; *Borosich v. Metropolitan Life Insurance Co.* (1926) 191 Wis. 239, 210 N. W. 829.

[4] *Schwartz v. Schneuviger* (1955) 269 Wis. 535, 69 N. W. 2d 756.

[5] *Prudential Insurance Co. v. Kozlowski*, footnote 3.

[6] Wis. Stat. Section 325.21 (3).

fication is necessary, it should be made by code rather than by recognizable name. Mr. McDavitt, in the article on hospital records earlier cited, suggests, "the least the hospital can do is to require the consent of the attending physician and to insist that the case records be used and presented in such a way as not to reveal" the patients' or physicians' identities. Such advice is consistent with the basic premise that the hospital is the custodian of its records as trustee for the patient and physician. The same premise underlies the rule of thumb with which this article opens.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1955, the March of Medicine began its tenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	4:00 p.m.
WBAY	Green Bay	Saturday	2:45 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Friday	1:45 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Saturday	1:15 p.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Fee Splitting

FEE splitting has been called "the buying and selling of patients on a commission basis." Wisconsin law calls it "a criminal fraud." Deceit is its vice. It occurs when the physician appears to be charging for only his own services, but in fact includes charges for either the professional services of others or someone's service in bringing physician and patient together. In the one case the patient is kept from knowing whom he is really paying; in the other, there is added the additional vice of a probable overcharge.

Section 147.225 of the Wisconsin Statutes has forbidden this practice since 1913. Even longer has it been frowned on by the profession itself, which condemns fee splitting even in those states where it is not forbidden by specific statute. The profession's continuing disapproval is evident from the *Principles for Establishing Medical Staff By-Laws, Rules and Regulations*, 1955 Edition of the Joint Commission on the Accreditation of Hospitals. These principles incorporate those of the American College of Surgeons and its *Manual of Hospital Standardization*, which require each hospital and each physician staff member to agree not to split professional fees.

In Wisconsin, the Supreme Court has never had occasion to hand down an authoritative interpretation of the fee-splitting statute. However, a request for an official opinion was made in 1914 of the attorney general of this state. By way of reply, he took up for consideration a variety of hypothetical situations. In each case where two or more doctors, or a hospital and one or more doctors, are involved, he found the only safe procedure to be for each doctor to contract separately for his services with the patient and then separately bill the patient for those services. None of the situations considered involved a group of two or more doctors practicing together as a medical partnership or clinic. But the attorney general's rule for the situations covered was plain. The patient must be billed by each physician for his own services. No physician may receive, either from a hospital or another doctor, any portion of what the hospital or other doctor billed the patient. The attorney general noted only two exceptions to the rule, and they are not exceptions so much as modified ways of conforming to the rule.

Such was the view of the office of the attorney general in 1914, a year after the original enactment of the fee-splitting statute. It was approved and reaffirmed by the same office in 1935, ten years after the statute's first and only amendment. Compare volume 3, *Opinions of the Attorney General of Wisconsin*, page 218, and volume 24, page 580. Though not as conclusive as a decision of the Wisconsin Supreme Court on a question of Wisconsin law, an attorney general's opinion is "official"; is authoritative in the absence of judicial decision to the contrary; and, especially if relied on by the public for many years, is likely to be followed by the courts themselves to avoid an upset of arrangements entered into in reliance on the opinion.

In the 1935 opinion, the attorney general disapproved the billing and paying arrangement where a family physician sent his patient to a surgeon who performed an operation for a standard fee, but then permitted the family physician to collect a single fee in installments over a period of time, and forward two-thirds of each installment until the entire surgical fee had been paid. The opinion does not directly so explain, but it seems probable that the mistake consisted in the collection of "a single fee." Had the two fees been *billed* separately, the arrangement might have been deemed satisfactory.

Neither of the attorney general's opinions passes on the question of a single bill rendered by a medical partnership or clinic for the services of more than one physician in the organization. It is probable, however, that such billing is permitted. The following language of subsection (3) of the statute, which was added as part of the 1925 amendment, seems to envision such an arrangement:

> "any physician, surgeon, nurse, anesthetist, or medical assistant *or any medical or surgical firm* or corporation . . . shall render an individual statement or account for his charges . . . distinct and separate from any statement or account by any other person, *firm* or corporation . . ." [Emphasis added]

Finally, it is difficult to believe that physicians who openly practice together in a partnership or clinic and bill in the same way could be deemed "guilty of criminal fraud" for so doing. It might well be otherwise where the same arrangements are in operation under a veil of secrecy.

Physicians and the Workmen's Compensation Act*

This article incorporates applicable changes through 1955 in statutes, court decisions, and Industrial Commission rules. In its preparation the State Medical Society has had the courteous cooperation of Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

Many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission; and incorporated in it are the thoughts and suggestions of its staff members.

Prior to 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. At the suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin, the State Medical Society of Wisconsin entered into a joint agreement with them to enlarge the panels through the voluntary cooperation of employers and the insurance companies in an effort to give the workmen of this state an opportunity to secure virtual free choice of physician. Through this agreement, any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel which is certified to the insurance company. This agreement makes it possible for approximately 80 per cent of the workmen in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. **The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon.** It is recognized that exceptions will occur to this portion of the agreement, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company association is as follows:

Agreement on panel practice in Wisconsin. The workmen's compensation law of Wisconsin requires "the employer to maintain a reasonable number of competent and impartial physicians, ready to undertake the treatment of the employe, and to permit the employe to make a choice of his attendant from among them." What is "a reasonable number" is for the commission to determine, taking account of the community medical resources and needs. In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. To provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representatives of the State Medical Society of Wisconsin established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because the obligation to pay is in the nature of a liability, those concerned with administration of the compensation act must find that three essential elements exist before an award can be made to an injured claimant. They are: (1) employer–employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment.

With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury. . ."

Collection of physician's account. It is important to keep in mind the ways in which the physician may be paid for services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, such employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, the physician must look to the injured employe for payment, except that ordinarily he can expect the Industrial Commission to determine any part thereof for which the employer is responsible.

Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment, and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment, or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness, but may, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician–patient relationship maintained. Generally, of course, communications from a patient to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege by providing that any physician who has attended an injured employe and files a claim for professional services under the act may be required to testify before the commission when it so directs. With reference to this the commission says:

> "It is a practical necessity that physicians attending injured workmen be permitted to furnish information to the commission upon which compensation can be based. Physicians will not be required, however, to disclose confidential communications communicated to them for the purpose of treatment unless such information is necessary to a proper disposition of the claim. The commission regards the physician who treats the injured workman at the request of the employer to all intents and purposes as the physician of the injured man. His testimony before the commission should be absolutely fair, factual and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently, of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The

members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however, (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company, and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is disputed by the employer or insurance company either as to the cause of the injury or illness, or its extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the commission invites attention to the case of *Philler v. Waukesha County* (1909), 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees.

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the commission as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

> "Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:
>
> Minor examination and report, not to exceed ..... $ 5.00
> Major examination and report, not to exceed 10.00
> X-rays where necessary to foregoing examination and report, not to exceed an additional 5.00
> Attendance at hearings on request of Commission:
> for first hour 10.00
> for each additional hour 5.00
>
> Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

It is recognized by the commission under present-day conditions that frequently larger fees are warranted and are allowed.

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician.

State employes. In the case of state employes who file compensation claims, the commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charges. Rule 18 provides in part:

> "The following reports and statements are required in claims for compensation or medical aid by an employe of the state.
>
> * * *
>
> "2. In all cases in which any disability results or medical expense is involved, a statement by the employe on form to be supplied by the Industrial Commission that he was injured in the course of his employment, reciting time and place of injury, the reasons for its occurrence, the nature of injury and stating all expenditures incurred for medical, surgical, hospital treatment, and medicines, to the time of the claim; whether claim is made for disability; if so, what period of temporary disability and

Physicians should submit their reports promptly to the commission. Delay may mean the withholding of compensation to the injured employe and of professional fees to the physician.

what permanent disability is claimed, and what salary has been paid by the state during the period of disability. If bills have been paid by the injured, receipts are to be attached.

"3. A report from the attending physician showing the nature of injury and the extent of disability. This may be made on form supplied by the commission.

"4. Bill from the physician and/or hospital itemizing services rendered and charges made. This need not be verified.

"5. A statement from the employing department stating whether injury occurred in the course of employment, and whether treatment is believed necessary as claimed. This will be made in conjunction with employe's statement and on the same form. If the department is unable to make statement the reason is to be stated."

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.53, 102.55 and 102.565 is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., nonschedule and schedule injuries.

Nonschedule injuries. Nonschedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts. Generally speaking, nonschedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of nonschedule injuries permanent disability is on the basis of a comparison between the nature of the *injury* and the nature of *an injury* causing permanent total disability. In the case of *Northern States Power Co. vs. Industrial Commission*, 1947, 252 Wis. 70, the court held that the fact that the injured suffered no actual loss of earnings did not deprive him for compensation for permanent disability based on permanent physical loss. The effect is to place so-called nonschedule types of injuries in essentially the same category as schedule injuries as to method of determination of permanent disability.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb*, having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been *amputated* at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the commission has found it possible to establish by custom or rule the related disability applicable to a given handicap.

After many hearings with physicians, and in cooperation with the State Medical Society, the commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Total ankylosis of arm at elbow at right angles	
With radio-ulnar motion intact	50%
With radio-ulnar motion destroyed (hand 45° less than fully pronated)	70%
Ankylosis of arm at elbow at 45° less than full extension with radio-ulnar motion intact	45%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%

Fingers

Complete ankylosis	Mid-position	Complete Extension
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10% =	1%	10% =	2%
	20% =	2%	20% =	4%
	30% =	3%	30% =	6%
	40% =	5%	40% =	8%
	50% =	10%	50% =	15%
	60% =	15%	60% =	20%
	70% =	20%	70% =	30%
	80% =	25%	80% =	40%
			100% =	60%
Middle joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	10%
	40% =	25%	40% =	15%
	50% =	40%	50% =	30%
	60% =	50%	60% =	50%
	70% =	60%	70% =	70%
	80% =	70%	80% =	90%
			100% =	100%
Proximal joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	15%
	40% =	20%	40% =	20%
	50% =	25%	50% =	25%
	60% =	30%	60% =	40%
	70% =	35%	70% =	75%
	80% =	40%	80% =	85%
			90% =	100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis—favorable position 10 to 15 degrees equinus without loss of inversion and eversion	30%
Ankylosis—favorable position with loss of inversion and eversion	40%
Loss of inversion and eversion with full dorsi and plantar flexion remaining	15%

Report form. For use in reporting disabilities under the compensation act, the commission has adopted forms for use of physicians.

In order to enable the commission to pass upon disability, it becomes necessary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to the regular form, the commission has adopted another form of physician's report under the new provision of Sec. 102.17 (1) (as), effective June 10, 1943, which provides that the contents of verified medical and surgical reports by physicians and surgeons licensed in and practicing in Wisconsin presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein, subject to such rules and such limitations as the commission may prescribe. So, likewise, reports of physicians and surgeons, wherever licensed and practicing, to whom the claimant has been sent for examination and treatment by the employer or insurer, are available as evidence provided the doctor consents to subject himself to cross-examination.

The purpose of this provision is to make it unnecessary for the physician to appear personally in some cases, especially where the issue in dispute is of a simple nature and it is desirable to avoid expense to the applicant in arranging for the personal appearance of the physician at the time of hearing.

In addition to these forms the commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

The law specifically provides that notwithstanding any other statutory provisions, any physician attending a workmen's compensation claimant may furnish to the employe, employer, workmen's compensation insurance carrier, or the Commission information and reports relative to a compensation claim. It provides further that a physician from outside Wisconsin may testify in compensation proceedings if he is licensed for the place of his residence or practice.

Forms are available upon request to the Industrial Commission.

Estimates of General Disability

Obviously methods of estimating must be in accordance with the law, regardless of the personal feeling of the physician as to the correctness or justice of the law. In general, parties are probably in agreement as to the essential justice of these provisions. However, physicians may at times have some doubt in individual cases as to the equity of one or other provision, or may feel that the law is harsh or inadequate from the standpoint of either employer or employe. That feeling should never be allowed to influence the physician, either in treating or in estimating disability.

The physician who estimates disability should, under no circumstances, concern himself with the result in number of weeks or in dollars but should confine himself strictly to the medical field in estimating the disability on a functional basis. The physician should never suggest that a case should be settled on a certain basis but should confine himself to setting out his pertinent findings. It is the function of the employer and carrier, not that of the doctor, to propose the basis for settlement. The doctor's function is to report his factual findings with the probabilities and possibilities which may be involved, leaving to the employer or carrier the suggestion as to whether or not settlement should be made and upon what basis. It is clear that if the physician is influenced by the amount of compensation which may be paid to the injured, his estimate will not be on a valid basis. Neither should physicians attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than one or another physician might consider to be equitable. Computation of compensation based on estimates of disability is a function for the Industrial Commission. Attempts of physicians to compute very often result in erroneous figures and thus cause confusion and misunderstanding, both on the part of the physician and the injured person.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength, of itself *does not necessarily mean 50 per cent loss of function of the limb.* All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks established by the commission, the physician must add or subtract such percentage as he believes will represent fairly the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of injured employes. Physicians have it within their power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

In this connection it should be pointed out that many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second and proximal joints. Some physicians refer to the first, second, third and fourth fingers, and some designate the thumb as the first finger. Also some physicians speak of the interphalangeal joints, and sometimes of the first, second and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reporting can be avoided.

As it is the commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the commission to check the report with the commission's standards and to arrive at an intelligent and uniform conclusion.

From time to time physicians propose certain standards or schedules for the measurement of disability. The commission wishes to call attention to the fact that no standards or schedules not adopted by the commission have the approval of the commission. Only those standards adopted and published by the commission itself should be considered as authoritative or as representing the commission's thought as to percentages of disability based on certain functional losses. It is appreciated that other schedules may be studied as a matter of interest by physicians who will undoubtedly wish to arrive at an opinion based upon their own examination and analysis and by reference to the standards which the commission has authoritatively adopted.

Estimates of Hearing Disability

In cooperation with representatives of the medical profession, insurance carriers, industry, and labor, the commission has worked out formulas for determining the loss of hearing suffered during the course and as a result of particular employments. These formulas are a guide at the present time and are primarily for the assistance of the examining physician. Copies of the formulas and associated material may be obtained by writing the commission.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical nature of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission stand ready to assist in solving some of the problems facing the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society, or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison 2, Wisconsin.

LIQUOR PRESCRIPTIONS

The friend may be penny wise, but the physician is pound foolish who prescribes for the friend's thirst or do-it-yourself proclivities rather than for his health. The friend will have the pleasure of his potion and perhaps the joy of a tax saving. But the physician will be subject to a fine of from $250 to $1,000 and to imprisonment for up to six months. If convicted twice, his license to practice may be revoked.

Section 176.19 of the Wisconsin Statutes imposes the above penalties for prescribing intoxicating liquors beyond what is necessary for health if done with intent to evade tax or license requirements for the sale of liquor.

Physicians and Child Placement

THE physician should avoid participation in any activity concerned with the placement of children with foster parents, beyond offering the suggestion that the parties involved should consult with either a licensed child welfare agency or an authorized public agency. Licensed child welfare agencies in Wisconsin are:

*The Children's Service Society of Wisconsin, 734 North Jefferson, Milwaukee 2.

Catholic Social Welfare Bureau, 2018 North Oakland Avenue, Milwaukee 2.

Catholic Welfare Agency, 1200 15th Avenue East, Superior.

Catholic Welfare Bureau, 3222 South Avenue, La Crosse.

Catholic Welfare Bureau, 119 East Washington Avenue, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa.

The Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

There are two authorized public agencies that will assist with child placement—Milwaukee County Child Welfare Division,* County Court House, Milwaukee 3, and Wisconsin Division for Children and Youth,* 311 State Street, Madison.

Maternity homes which are licensed in Wisconsin to serve prospective unmarried mothers are:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 2224 West Juneau Street, Milwaukee 8.

St. Ann's Maternity Annex (Catholic), 1020 Market Street, La Crosse.

St. Mary's Home (Catholic), 403 South Webster Avenue, Green Bay.

*Summit Hospital, Oconomowoc.

Fees for care vary from $80 to $150, covering prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover the cost of service rendered.

The 1955 legislature, in enacting a new Children's Code, amended the sections of the Wisconsin Statutes formerly restricting the activities of unauthorized persons in connection with adoption. In doing so, as of July 1, 1955, it strengthened the earlier restrictions. Under the former statutes, as interpreted by the Wisconsin attorney general in 37 O.A.G. 403 (1948), physicians could not assist in bringing together adoptive parents and a child available for adoption. Physicians who did assist were subject to criminal penalties imposed by law. Under the law as revised, the physician undergoes a similar risk if he undertakes an active role in placement, negotiation, action as an intermediary, or indication of an ability to place a child in a foster home.

The new applicable sections of the statutes are as follows:

"**48.63 Restrictions on independent placements.** (1) No person, except the child's parent or guardian or the department, a county agency performing child welfare services under s. 48.56 (1), a child welfare agency licensed to place children in foster homes, or a court of record, may:

(a) Place a child or negotiate or act as intermediary for the placement of a child in a foster home; or

(b) Offer or hold himself out as able to place a child in a foster home.

(2) No parent or guardian, except a licensed child welfare agency or public agency authorized to place children for adoption, may place a child in a foster home for adoption without obtaining the written approval of the county court. The court shall, before taking action to approve or disapprove, have an investigation of the facts and a report made by the department, a county agency performing child welfare services under s. 48.56, or a child welfare agency licensed to place children in foster homes."

"**48.74 Authority of department to investigate alleged violations.** Whenever the department is advised or has reason to believe that any person is violating any of the provisions of ss. 48.60, 48.62 or 48.65, it shall make an investigation to determine the facts. For the purposes of this investigation, it shall have authority to inspect the premises where the violation is alleged to occur. If it finds that the person is violating any of the specified sections, it may either issue a license if the person is qualified or may institute a prosecution under s. 48.76."

"**48.76. Penalties.** Any person who violates ss. 48.60, 48.62, 48.63 or 48.65 may be fined not more than $500 or imprisoned not more than one year in county jail or both."

Upon enacting the Children's Code in 1955, the legislature declared it to be the policy of the State of Wisconsin to consider as paramount the best interests of the child. The interest of the parents or guardian of the child, together with the public interest, are to be considered also, but only secondarily. Wis. Stat., 1955, Section 48.01 (3).

Physicians who attend either unwed mothers or married couples eager to adopt a child may, as a result of friendships formed through close contact,

* Non-denominational.

acquire unwittingly a greater concern for the welfare of the parents, natural or adoptive, than for that of the child. For this reason, it is especially important for the physician to direct the adult parties involved to agencies that have been established by the state specifically to carry out the policy which the Children's Code sets forth.

In view of Wisconsin's policy as proclaimed by the legislature for the Children's Code, together with the criminal penalties inflicted for violation, the physician must not:

(1) suggest to any unmarried mother, other natural parent, or legal guardian any particular foster parents for a child whom he deems available for adoption;

(2) offer to find foster parents for such a child;

(3) offer to find a child for adoption by prospective foster parents;

(4) place a child with foster parents on a trial or any other basis;

(5) act in any other way as negotiator or intermediary in such matters; or

(6) in any other way risk possible violation of the clear terms of the statute.

It is impossible to emphasize these points too vigorously. It is essential that the physician avoid conduct that could cause him to appear in the public eye as associated with the "bootlegging of babies." If prosecuted under the above provisions of the Children's Code, he could easily appear so, even though he should eventually win an acquittal.

If questions arise concerning particular cases, the physician should consult the Division for Children and Youth, 311 State Street, Madison 2, Wisconsin. This is the state administrative agency in charge of such matters.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 52.36, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation, or even requested it.

THE MEDICAL FORUM

PUBLIC CLINICS EXPECTED TO GET VACCINE BY MARCH

New Milwaukee Society Head Urges "Make Blue Shield Plans Work"

Milwaukee—Dr. Jerome W. Fons, newly-elected president of the Medical Society of Milwaukee County, urged fellow physicians Dec. 6 to help make Blue Shield plans work by developing *"realistic income levels."*

He referred to the feature that requires doctors to accept the Blue Shield fee as full payment for services when a patient's income is below a stated level.

RECORD ATTENDANCE

Dr. Fons spoke at the Society's annual meeting. More than 600 of the group's 1,132 members attended—a record turnout.

The new president departed from his prepared text to comment on the current controversy over division of the Blue Shield fee paid for surgery. Some doctors contend the fee should be paid only for surgery and not for other care incidental to a patient's hospitalization.

EXPLAINS VIEWS

Dr. Fons said the fee in the surgical scale should "never be interpreted only for the mechanical features of surgery, but should also include pre- and post-operative care given a patient, whether rendered by a surgeon, a generalist, the family doctor or another doctor."

He explained that in Milwaukee County, under the Surgical Care plan "a Blue Shield blank is sent to the doctor of record, the first to meet and treat the patient.

PAYMENT PLAN

"When this physician feels the need of calling in a surgeon, he does so. In the blank the doctor of record indicates the role of the surgeon, who then receives a separate blank from Surgical Care. Two checks are sent out, and the patient notified of what transpired in payment."

Dr. J. W. Fons

A general practitioner, Dr. Fons is Speaker of The House of Delegates of the State Medical Society, and chairman of the board of the Wisconsin academy of General Practice.

The new top officer succeeds **Dr. David V. Elconin. Dr. George S. Kilkenny** was named president-elect; **Dr. David W. Ovitt**, secretary; **Dr. Edwin C. Welsh**, treasurer; **Dr. Donald T. Hughson** and **Leo R. Weinshel**, members of the committee on credentials, and **Dr. Elconin**, to the board of directors.

BENEFITS, INCOME UP

Major accomplishments of Surgical Care for the last year were cited as follows:

Increased income to an annual rate of $4,550,000.

Increased benefits paid to an annual rate of $3,625,000.

Developed a contract amendment which provides for diagnostic x-ray and laboratory services in or out of a hospital.

Made available a "specific diseases" certificate under which payment is made for the services of a physician in or out of the hospital, plus other ancillary medical services in treatment of nine dread diseases. This contract pays up to $10,000 in benefits for each participant.

Initial Injections Planned for 10% of All Youngsters

Madison—The State Board of Health expects to have polio vaccine available for public clinics early this spring.

A Board spokesman said the action followed a recommendation of the subcommittee of the State Polio Vaccine Advisory Committee, pressure because of newspaper, radio and TV publicity and a desire to facilitate the vaccination program.

SUPPLY ON HAND

The Board, in a bulletin sent Dec. 19 to city health officers, city nursing services and county nurses, said sufficient vaccine would be available to give the first two injections to 10 per cent of individuals in the present eligible classification, i.e., under 15 years and pregnant women.

Requests for the vaccine for public clinics must be sent to the Board before March 1.

"The period mentioned cannot be made more definite because the supply of vaccine which has been available for purchase by the Board has been variable and inconstant," the bulletin stated.

ORDERS TO FILL

"The Board now has a backlog of physicians' requests for vaccine. Although the receipt of such requests was cut off (as of Dec. 31) until further notice, these requests will be filled as vaccine becomes available. Therefore, it is impossible to predict with any degree of accuracy when vaccine for public clinics will become available.

Only communities with full-time health personnel are eligible to receive state-purchased vaccine for the conduct of public clinics. The approval of each county medical society for the conduct of these clinics is required.

(Continued on page 52)

VACCINE . . .

(Continued from page 51)

It will be unnecessary for a public health group to determine the number of individuals in present priority groups within its jurisdiction. The bulletin stated that reasonably accurate information of this type is available to the Board.

SCHEDULES UNCERTAIN

The Board recommended that local health services do not establish definite dates at present for staging the public vaccination clinics. This is due primarily to variability in availability of vaccine to the Board in respect to both frequency and quantity.

As soon as it is possible to do so, the Board will notify each local health service from whom it received proper requests as to when that agency will receive vaccine.

Present recommendations are that the first two injections be spaced four to six weeks apart. Other information stated:

LIMIT AGE GROUP

That the local agency narrow the age group eligibility for each community. This will not affect the total amount of vaccine receivable from the Board.

That signed parent request forms be received for persons in the narrowed age group. After this is obtained, it can be determined whether sufficient vaccine will be available to expand the age group by one, two or more years.

That, according to federal law, "no means test or other discrimination based on financial ability of individuals will be imposed to limit eligibility of persons to receive vaccination."

That records be maintained and supplied to the Board.

OFFICIAL OK NEEDED

The bulletin stated that while vaccine may be purchased by local and state government agencies for use in the clinics, manufacturers will not fill such orders unless accompanied by State Board of Health authorization.

Inasmuch as the Board must use its federal funds ($610,000) for purchase of vaccine as soon as possible, it appeared unlikely that vaccine would be available for other public agency purchase for quite a period of time, depending on speed of production and approval of the vaccine by the U. S. Public Health Service. It also was deemed unlikely that such vaccine would be available to communities to supplement the state-purchased supply for public clinics at the time such clinics may be conducted. The board recommended that no dependence be made on other sources for use in the near future.

Changes in Narcotic Drug Prescription Laws Clarified

Madison—Changes in regulations pertaining to oral and written prescriptions for narcotic drugs in Wisconsin were clarified for physicians by Dr. Carl N. Neupert, State Health Officer, in December.

The 1955 legislature modified state law to permit use of oral prescriptions by physicians for paregoric and certain narcotic drugs found to possess little or no addiction liability. It also redefined the term "narcotic drugs" to include synthetic narcotics, with written prescriptions required for all preparations not specifically listed in federal regulations for oral prescriptions.

ORAL LISTING

Federal changes placed the following drugs on the oral prescription list: codeine, nalline, isoquinoline, nalorphine, hydrocodone, apomorphine, dicodid, hycodan, oxycodone, eucodal and dionin.

Two congressional subcommittees spent the past few months investigating various aspects of the narcotics problem. Hearings were held in San Francisco, Los Angeles and Washington in December, winding up the schedule. Reports are expected in the near future.

ADDICTION NOTED

Of particular concern to the subcommittees was barbiturates. It was indicated federal control of these drugs might be asked, a course opposed by the AMA and the Federal Bureau of Narcotics. Spokesmen for the U. S. Public Health Service have said that barbiturate addiction is widespread.

Another issue concerned methods of battling addiction. Some witnesses recommended establishment of clinics where addicts could obtain narcotics under medical direction but at a cost low enough to wipe out drug racketeering.

AMA Official Urges Improved Doctor–Public Relations

Boston—The President-Elect of the AMA believes much improvement is needed in present-day relations between physicians and the public.

Dr. Dwight H. Murray spoke before the Eighth National Medical Public Relations Conference which preceded the opening of the AMA clinical session in late November.

In his speech, he declared:

"We should work even harder than before to further improvement in our relationship with the press. We should learn to tell our story in such a way that is always newsworthy.

"GET OFF PEDESTALS"

"No one is going to give a hoot about the problems of the medical profession if we sit on our pedestals waiting for others to come to us. Whatever political battles we may have won in the past were not won by the physicians alone; victory was achieved only through the support of millions of other voters. Many of them feel even more strongly about the threat of socialism than we do.

"Unfortunately, most of our good medical public relations begin and end in each doctor's office. Outside of his office, many a doctor shields himself from contact with other citizens . . . like a cloistered nun.

"BE GOOD NEIGHBOR"

"Is it any wonder, then, that we get the feeling so often that nobody understands us and our problems? How can they? We never give other people a chance to know us. Do we understand our neighbors and the rest of the citizens of our respective communities. Hardly."

Dr. Murray said doctors "know patients' tonsils, appendices, livers and kidneys . . . but we don't know what makes them tick as fellow human beings who live and eat and work and play just as we do."

He added:

"If we would but stop and look around we would learn that we have many things in common with our neighbors, and they would be very willing to help us with our problems if we would help them with theirs."

"Faith Healer," Disclosed by Madison Newspaper as Fake, Quickly Departs

Madison—Because of the heat whipped up by *The Capital Times*, an Ohioan who staged a "trance seance" here in November left town convinced he had better "practice" elsewhere.

At his meetings, the Rev. Stanley B. Matrunick purported to go into a trance during which an imaginary Indian spirit named "Many Feathers" counseled people in the audience on health, medical, family and other matters.

SHOW HALTED

The Rev. Amelia Pope, pastor of the Madison church used for the seances, cancelled further appearances of her guest after *The Capital Times* reported the observations of two reporters, one of whom allowed herself to be subjected to a private "healing" consultation.

The Rev. Pope described the "trance seance" as a "fake," and not in accord with the principles of her church. She said:

"We do not uphold fake mediumship. I will never allow this kind of work in our church. The whole thing was misrepresented to us. I am exposing this man to every church I can contact to warn them against him."

The Rev. Matrunick described himself as a traveling missionary with engagements six months ahead.

"Is it actually a majority or a minority calling me a fake?" he asked.

"I am a licensed minister of the Ohio Spiritualist Association and a missionary of the White Lily Chapel at Ashley."

RADIO TO PULPIT

The reporter who received the "healing" consultation was promised quick recovery of her ailments "through faith."

The State Medical Society checked on Rev. Matrunick's background and learned he had been a radio repairman before entering his present field several years ago. He charged a fee for his seances, he said, "to exclude the curious and those who hold our religion lightly."

Basic Science Exams

Madison—The Wisconsin State Board of Examiners in the Basic Sciences will hold examinations in Madison April 7 and in Milwaukee June 2.

The Rev. Stanley B. Matrunick, self-styled "faith-healer" from Ashley, O., is shown above (center) conducting a "trance seance" at a Madison church. At his right is Mrs. Matrunick. The others in attendance were not identified. The doll display in the right background belongs to The Rev. Amelia Pope, pastor of the church used for the seances. The Rev. Pope described the "psychic pictures" of the visiting trance specialist as "fake."—*(Madison Capital Times photo)*

DR. SCHWADE WINS LENNOX AWARD

New York City—Dr. Edward D. Schwade, Milwaukee neuropsychiatrist, was awarded the William G. Lennox citation Dec. 8 for service in the field of epilepsy.

The award, $100, is presented by Dr. Lennox, of Boston, for research and teaching in epilepsy.

Dr. Schwade, head of the division of nervous and mental diseases of the State Medical Society, has been active in promoting changes in Wisconsin statutes that had barred epileptics from marrying and obtaining drivers' licenses and that provided for committing them to state institutions on the same basis as the mentally retarded.

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TB AMONG MENTALLY ILL MAJOR CONCERN, ACTION URGED

State Official, Doctors Urge S.M.S Action

Milwaukee—A State Department of Public Welfare official believes the State Medical Society has a responsibility to say "Wake Up, Wisconsin," in reinforcing efforts to wipe out tuberculosis among the mentally ill.

Dr. Leslie A. Osborn, director of the Department's division of mental health, voiced his views at a recent meeting of the Society's Division on Nervous and Mental Diseases with the Division on Tuberculosis and Chest Diseases in Milwaukee. Dr. Osborn is also director of the Wisconsin Psychiatric Institute.

He said:

COMPLACENCY NOTED

"One of the biggest risks in public health work today is that, when part of the job is done, the people think the whole job is done. The people think tuberculosis is whipped. This is far from true.

"If not controlled in county hospitals, people being released from county institutions will re-infect the entire community. Neither the public nor the legislature understands the problem.

NO LETUP

"Let's reinforce our efforts and clean up the problem. We have the leadership to show how it can be done. We need financial support and public understanding of a grave health problem."

Dr. Kathryn Schwerma, of Madison, reported that in 1954, more than 6.2 per cent of the mental cases had TB. Of 13,000 patients in mental hospitals a year ago, approximately 1,000 were known to have the disease in an active or inactive state.

There were 210 deaths from TB in 1954, and of these, 26 occurred in mental hospitals.

Dr. Schwerma said:

RECOMMENDATIONS OUTLINED

"There are 25 times more deaths from tuberculosis among mental patients than there are among the general population with the disease. There are far too few beds for TB patients who are mentally ill. There still is a great deal of education to be done.

Dr. L. A. Osborn

"Many county hospitals need to set up admission x-ray programs so as to screen out the mentally ill patients who have TB upon entering. The Department of Public Welfare has encouraged tuberculin skin testing among mentally ill patients, and they find that positive tests range from 65 to 90 per cent, considerably higher than the non-institutionalized population."

MORE UNITS

It was explained that the State Board of Health mobile unit cannot get to county mental hospitals more than once every three years. It was generally agreed the units should visit these hospitals once a year, but to do so would require 10 mobile x-ray units instead of the three now in operation.

Dr. Milton Feig, of the State Board of Health, said the biggest problem of TB control is in the county mental hospital.

FUNDS ESSENTIAL

"There is a problem," he said, "that the Board and the Public Welfare Department can't seem to persuade the medical directors or the administrators of these institutions to follow up known or suspected TB cases."

Another speaker, Dr. A. A. Pleyte of Milwaukee, said the primary objective in control of TB is the isolation of the open case.

"We must at least double our discovery program," he said. "Surveying members of mental institutions once every three years is woefully inadequate. There is no excuse for the current handling of this problem. Dollars are needed, because people get out of these institutions and are seed spreaders when they get home.

"The best way to treat them from the mental and TB standpoint is to make them well and to break the chain of infection. Our problem, too, is to find the reactors."

URGES STREAMLINING

Dr. W. D. Stovall, Madison, director of the State Laboratory of Hygiene, commented:

"Too much specialization in medicine is hindering treatment. First we have to find the case, then send it to a place where treatment can be had for both mental and TB diseases.

"The sanatorium at Wales won't take the mentally ill because of the stigma that makes people think those who went there are both crazy and tuberculous.

"Hospitals don't have diseases . . . people have them."

ON THE S.M.S. CALENDAR. . .

February

5—10th District Blue Shield Plans Meeting, Omaha.
6-8—Medical Society Executives' Conference, Chicago.
7—Claims Committee, SMS.
11-14—Congress on Medical Education and Licensure, Chicago.
14—Post-Graduate Clinic, Janesville.
16—Post-Graduate Clinic, Stevens Point.
16—Post-Graduate Clinic, Green Bay.
25-26—Council Meeting, SMS.

March

2-3—Tri-State Conference on Health in Colleges, Highland Park, Ill.
6—Claims Committee, SMS.
8—National Rural Health Conference, Portland, Ore.

New Food Film Available

Chicago—A new film, "Eat for Health," to illustrate patterns for food selection in children, is available for $2 through the AMA's Committee on Motion Pictures and Medical Television. Showing time is 11 minutes.

EMERGENCY CHILDBIRTH CLINICS WIN HIGH PRAISE

Madison—One-day clinics on procedures to follow in emergency childbirth cases, conducted throughout the state for police officers, won high praise from participants.

Held in November and December, the sessions were arranged under sponsorship of the State Medical Society, the Wisconsin Chiefs of Police Association and the Wisconsin Sheriffs and Deputy Sheriffs' Association. The Milwaukee office of the FBI coordinated the clinics in 24 communities.

ART SUBJECT

The officers were generally agreed that while the subject of their training manuals or courses childbirth isn't covered in any of it is a problem meriting their attention and study.

From a veteran Madison policeman: "I've heard three lectures on this subject, but this was the first time I've been able to understand what I was supposed to."

From a Dane County deputy sheriff: "I certainly wish I had this knowledge before. It's very helpful and practical."

"VERY GOOD"

From a small-town officer: "The program was very well done. It's very good."

From one of the participants in Wausau: "The material was presented in every-day language by the doctor. It was thoroughly understood by all attending."

From a police chief in Columbia County: "My only suggestion is that we have more of this type of training. We all appreciate the fact these doctors took the time to give us this instruction. It was very well handled."

PUBLIC SERVICE

From La Crosse: "Very good. Well received."

From Chippewa Falls: "Dr. Earl Hatleberg, in the minds of all of us, rendered a splendid service, well delivered, easily understood, gratefully received and appreciated."

From an undersheriff in Waukesha County: "A presentation of this kind should be included in officers' training. They should have knowledge as to what to do and may be influential in saving lives."

From a police chief in Grant County: Dr. John W. Conklin did a swell job. He impressed upon us that only in extreme emergencies should an officer attempt a birth. He talked to us in a manner we could understand. I am sure every one attending benefited."

Wrapping and care of newborn babies was demonstrated by Dr. D. L. Williams at a clinic in Madison wherein police officers received instruction on childbirth emergencies. With Dr. Williams (holding doll used in demonstration) above are Tom Muldowney (left) and Bill Hughey, of the Dane County Traffic Department, and Traffic Sgt. Norman Ehle (right), of the Madison police department—*(Madison Capital Times photo)*

WIDE FIELD

Subject matter at the sessions included description of minimum equipment for emergency care and possible substitutions, ways of appraising situations, instructions for delivery, care of newborn infant and mother, and advice for meeting abnormal situations.

More than 50 Wisconsin physicians assisted in the clinics.

National Conference on Rural Health in Oregon

Portland, Ore.—The 11th National Conference on Rural Health, sponsored by the AMA's Council on Rural Health, will be held here March 8–10. Theme of the meetings will be "Your Doctor and You."

Major topics will include mental health, programs for older people, the family physician, prepaid medical care and successful community enterprises.

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November 23, 1955

Joseph A. Navarre
Commissioner of Insurance
Lansing, Michigan

Dear Commissioner Navarre:

We in the UAW-CIO are gravely concerned about the increasing cost of prepaid hospital care as reflected in the proposal by the Michigan Hospital Service Plan (Blue Cross) for a rate increase of 23% to take effect February 1, 1956. If granted, this would be by far the greatest rise in subscription costs since the Plan began. It would cost a family approximately $9.10 a month for hospitalization insurance alone, and would definitely place the cost of such protection outside of the means of a great number of people in Michigan. Especially hard hit will be retired workers and those who do not have employer contributions to defray all or part of the premium cost.

After careful consideration of the data and arguments advanced by the Plan, the two trade union representatives on the Blue Cross Board of Trustees voted against the rate increase.

We recognize that the Plan provides a high level of benefits and that hospital costs are going up. We appreciate the Plan's need for a sound rate structure and adequate reserves. However, Michigan Hospital Service has failed to demonstrate the need of so large an increase in rates. The justification of the rate increase is defective in many respects. I will be glad to have technicians from the staff of our Union review them with you. To cite one example: the Plan is assuming an increase in daily hospital costs per patient of $2.90 and $3.20 for 1956 and 1957 respectively. This is almost twice the actual average increase over the last five years, and these years have included very substantial reduction in the hours worked in hospitals, considerable increase in hospital wages and the introduction of pensions and other benefits. The plan is assuming that hospital costs will not only continue to increase, but contrary to actual experience, that they will rise at an ever increasing rate.

This is nothing less than alarming. There is a great danger under prepayment plans that some hospital administrators will feel that anything goes; that their costs, whether justified or not, will be passed on to the consumer. There is a question whether the hospitals have enough incentives to economize; whether there is unnecessary use of drugs, laboratory, X-ray and other facilities, and whether doctors are abusing hospital care and adding to the cost of prepayment. The Commissioner on Financing of Hospital Care admitted that "the use of prepayment has to some extent reduced, if not removed, incentives which would otherwise operate to encourage maintenance of hospital operating costs at the lowest levels practicable."

Commissioner Joseph A. Navarre
November 23, 1955
- Page 2 -

The Medical Director of the Michigan Hospital Service has reported that "to effect major savings (in Blue Cross costs) one must look for major defects in the present system of supplying hospital care. It is our belief that such defects exist and that their reduction could offer hope for a considerable reduction in the expense of hospitalization to the patient". This physician also reported that prepayment has resulted in millions of unnecessary days hospital bed occupancy and many millions of unessential procedures. "This", he said, "perhaps more than any other factor, is presently pricing hospital care out of the pockets of lower income segments of our population".

Michigan Hospital Service has not dealt decisively with the major problems involved. Last year they instituted co-insurance and deductible provisions which did not meet the problem and were unacceptable to subscribers.

We have repeatedly pointed out the necessity for exercising medical control over hospitalization, and for adopting procedures which would give hospitals incentives to operate more efficiently and economically. These have not been adopted.

We have also advocated experimentation to provide out-patient services which would make it unnecessary for patients to occupy a bed when they might receive the same services on an ambulatory basis. The UAW has offered to encourage experimentation with needed additional benefits which would improve the services to the subscribers and help eliminate unnecessary hospital care. These logical program extensions have not been tried.

If once again too large a rate increase is allowed, hospitals, physicians and the Blue Cross Planwill have no incentive to step up to their responsibilities.

We therefore urge you to:

1. Disallow the 23% rate increase;

2. Order a complete review of the factors which cause unnecessary inflation of Blue Cross costs;

3. Require the Plan to call in an outside agency, qualified in the fields of health services and prepayment, to conduct studies and make recommendations with a view to finding a valid solution to the recurring problem of assuring a high quality prepaid hospital care at reasonable cost.

Sincerely yours,

Walter P. Reuther

Walter P. Reuther, President
International Union, UAW-CIO

WPR:lbh
Liu72cio

EDITOR'S NOTE

Mr. Reuther's letter is self-explanatory. It also was sent to presidents of all Michigan local unions and to Gov. G. Mennen Williams, asking for a review of the proposal.

Wisconsin Crime Lab Chief Raps State Medical Examiner Proposal

Madison—Foes and friends of a proposed medical examiner system for Wisconsin spoke up at a hearing here Dec. 9.

Charles M. Wilson, director of the State Crime Laboratory, said the system "might even destroy the laboratory, and its creation, to take over most of the duties of county coroners, would duplicate much of my agency's efforts."

The hearing was conducted by the Legislative Council's judiciary committee.

Wilson said:

PREFERS CORONER

"A general practitioner is totally untrained to perform an autopsy in a murder case, unless he has had special training. If it's a question of deciding between a general practitioner and an experienced coroner, I would pick a coroner."

Wilson said there is a great need for trained pathologists to conduct autopsies, but creating the proposed system "would not provide them."

He continued:

NOW A "VACUUM"

"Medical schools should begin now to train pathologists so they would be available 10 years from now. The present coroner system has its faults but the proposed medical examiner system is not the answer. It would create more problems than it remedies. The subject of legal medicine in Wisconsin is practically a complete vacuum at this time."

He directed his criticism at the type of system proposed by the 1955 legislature, which later directed the Council to study the plan.

WILSON REFUTED

Several of the proponents for the system said Wilson's fears were unfounded.

Favoring the proposal were spokesmen for the State Medical Society, the Wisconsin Bar Association, Dr. L. J. Van Hecke, Milwaukee County medical examiner; Dr. D. Murray Angevine, of the University of Wisconsin Medical School; Dr. M. B. Llewellyn, Janesville pathologist; Madison Police Chief Bruce Weatherly; the Wisconsin State Association of Pathologists and the Wisconsin Funeral Directors' Association.

Dr. L. J. Van Hecke

Dr. Van Hecke said:

"There would be little need for a change if laymen coroners would take their job seriously and perform their duties conscientiously.

VALUES DETAILED

"There would be nothing willy-nilly about the new system. It would also eliminate current hazards of political campaigning. There are defects in the present law; the new system would eliminate these weaknesses. And the cost probably would not be as great as anticipated earlier."

These statements were reiterated by Dr. Llewellyn, who added: "Physicians feel their obligation to the public, and would be willing to do their part in the proposed plan."

KEMPS SPEAKS

Opposition also came from Bernard H. Kemps, of Appleton, president of the Wisconsin Coroners' Association. He defended the present system and argued that improvements therein would result from several 1955 laws. He also said two-day training courses for coroners, now voluntary, should be made compulsory.

He said:

"Doctors are too overworked to be chasing coroner cases. If they were paid according to medical practice, the cost to the taxpayers would be almost prohibitive and the results would be no better . . . Put teeth in the present system, and Wisconsin will have one of the best coroner systems in the country."

Initiate Plan to Draft Medical Care Standards in Counties

Madison—Local medical society officials are asked to work in the near future with county welfare directors to formulate uniform standards relating to provisions of medical care, in accordance with a directive of the State Department of Public Welfare's Division of Public Assistance.

Plans for such standards were issued to county welfare agencies as of Dec. 15, 1955. In 1953 the state Legislative Council asked the welfare division to review care for recipients of old age assistance, aid to the blind, dependent children and totally disabled persons' benefits.

POLICIES FORMULATED

Endorsed by the State Medical Society's Commission on State Departments and its Division on Public Assistance, the plans set up general principles and a framework within which county systems are to be developed. This will cover such things as fee schedules, physician-advisory services and working agreements on matters of mutual concern to the county welfare agency and the physicians providing the care.

The changes from present practice undoubtedly will vary from county to county, with some finding only minor adjustments necessary.

Included were comprehensive operating instructions, which county agencies are obliged to follow in providing for the various needs of public assistance recipients.

CARE DETAILED

Health care, termed "medical care" under the adjusted standards, will include physicians' services; hospitalization; home care when prescribed by physicians; nursing home care; drugs, medical supplies and equipment; prosthetic appliances and other services prescribed by physicians; prepayment of medical care; transportation to obtain such care; optometrical services; dentists and nurses' services.

Dr. Hein Elected

Kansas City, Mo.—Dr. Fred V. Hein, former supervisor of health and physical education in the Oshkosh (Wis.) public schools, is the new president-elect of the American School Health Association.

Legal Aspects of Abortions

WISCONSIN'S new Criminal Code, which will become effective on July 1, 1956, makes important changes affecting the legal aspects of abortions. On and after that date, Section 940.04 of the Wisconsin Statutes will govern. It will read as follows:

"940.04 Abortion. (1) Any person, other than the mother, who intentionally destroys the life of an unborn child may be fined not more than $5,000 or imprisoned not more than 3 years or both.

(2) Any person, other than the mother, who does either of the following may be imprisoned not more than 15 years:

(a) Intentionally destroys the life of an unborn quick child; or

(b) Causes the death of the mother by an act done with intent to destroy the life of an unborn child. It is unnecessary to prove that the fetus was alive when the act so causing the mother's death was committed.

(3) Any pregnant woman who intentionally destroys the life of her unborn child or who consents to such destruction by another may be fined not more than $200 or imprisoned not more than 6 months or both.

(4) Any pregnant woman who intentionally destroys the life of her unborn quick child or who consents to such destruction by another may be imprisoned not more than 2 years.

(5) This section does not apply to a therapeutic abortion which:

(a) Is performed by a physician; and

(b) Is necessary, or is advised by 2 other physicians as necessary to save the life of the mother; and

(c) Unless an emergency prevents, is performed in a licensed maternity hospital.

(6) In this section 'unborn child' means a human being from the time of conception until it is born alive."

Therapeutic Abortions

The last sentence of the new statute, defining "unborn child," coupled with the fact that no mention is made of "miscarriage" as distinguished from "abortion," results in a valuable improvement of the law.

Under the old statutes, which will continue in force through June 30, 1956, therapeutic necessity would clearly protect the honest practitioner only if charged with the greater crime of committing an illegal "abortion"; it would not clearly protect him if charged with the lesser crime of procuring an illegal "miscarriage." Two separate statutes have dealt with these two crimes: Section 340.095, making it third degree murder to cause the death of either mother or child by administering to the mother with intent to destroy the child, *in the absence of need for such administrations to preserve the life of the mother,* and Section 351.22, making it a lesser felony to administer to the mother with intent to procure a miscarriage, *without making any mention of need for such administration.* In construing these statutes, the courts have treated the former as applying only where there was a *living child,* which, in their practice, required a pregnancy that had advanced over a minimum of four to five months. The latter, or "miscarriage" statute, applied where the pregnancy was in the early stages.

The new statute, by the penalties which it prescribes, continues a distinction between greater and lesser crimes. Intentional destruction of the life of any unborn child permits a fine up to $5,000 and imprisonment up to three years. If the life destroyed is that of a quick child or of the mother, the imprisonment may be up to 15 years. But no matter what life is destroyed, the new statute imposes no penalty if the acts causing the death had therapeutic purpose and (a) had been performed by a physician, (b) had been in fact necessary to save the life of the mother, or apparently so on the advice of two other physicians, and (c) had been performed in a licensed maternity hospital except where emergency prevented.

It is to be noted, of course, that therapeutic abortions are not always legal, but only in those cases where *all* of the three conditions specified are fulfilled. It is to be especially noted that therapeutic necessity, to be sufficient, is not based simply on danger to the mother's health; it must be based on danger to her life.

Improved Enforceability

Perhaps the greatest improvement in the new statute is that which makes performance of therapeutic abortions in a maternity hospital, except where emergencies require otherwise, a necessary prerequisite to legality. This, more than anything else, should make it easier for law enforcement agencies to combat the abortion racket.

Heretofore, criminal abortionists, operating behind the doors of either their private establishments or their victims' homes, have often relied on their ability to argue that their administrations were necessary to save the mother's life. In the future, they will still have that task, but will have also the much more difficult task of arguing that the mother's life was in such immediate danger that there was no time to remove her to a licensed maternity hospital.

Necessity of Reporting Case

Unaffected by the Criminal Code is Section 366.20 of the Wisconsin Statutes, which requires in part that *all* physicians immediately report to the sheriff, police officer, or coroner of the county within which occurs a death following an abortion, when such a death is within a physician's knowledge. Noncompliance is a misdemeanor, punishable by fine or imprisonment. Although there has been no judicial interpretation of this requirement, it is the opinion of legal counsel that it is intended to apply *only* to those situations in which the mother dies following an abortion and not to the destruction of a fetus.

The prudent physician will adopt safeguards over and above the statutory requirements in such cases. When consulted by a woman who has been treated by an abortionist, the physician should try to insist upon a complete disclosure by the patient to proper authorities, although this is frequently difficult if not impossible to accomplish. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death.

What should the physician do under such circumstances? Primarily, his duty is to his patient, and he should do the best he can for her up to the time it seems probable that she will die as a result of a criminal abortion or miscarriage. At that stage, it would seem advisable to afford the district attorney a chance to obtain a statement from the patient. No harm can come from such a procedure, for if the patient dies, the physician is bound to report the cause of death, and then he must either disclose the fact on the death certificate that the patient died of an artificially produced abortion, or he must accept the responsibility for being an accessory-after-the-fact by concealing the cause of death. If the patient dies, and it becomes known either through the physician's death certificate or otherwise that a criminal abortion is suspected, the part the physician played in the case will become a matter of public notoriety in connection with any inquest that may be held, and the physician's reputation will be subjected to suspicion at the least. People will wonder what motive he had for failing to give the prosecuting attorney the opportunity of obtaining a dying declaration.

After-Treatment

Neither the existing law nor the new Criminal Code deals directly with the position of a doctor called to treat a patient suffering from the effects of an attempted or completed abortion. His situation is a difficult one, and may be precarious as well.

Not infrequently the abortionist merely starts the procedure, advising the woman to consult her own physician for all future care. It may sometimes be difficult for the physician to identify criminally induced cases, as distinguished from cases with natural causes, since most women are hesitant to make such an admission. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

Physician Consultant; Statement by Patients

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that procedure used in the course of treatment was itself the activating cause of the abortion or miscarriage.

In an emergency case, when no other physician is available, it is proper to insist that the patient sign a written statement, in the presence of witnesses, if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after an understanding that the physican may use the statement in event he later requires it for his protection. In every instance complete, detailed patient records should be maintained.

In *State v. Law* (1912), 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

POSTMORTEM EXAMINATION

A great deal of confusion always existed about whose consent was required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Now, under Section 155.05, Wisconsin Statutes, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Death Certificates

IN WISCONSIN a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal, and "a complete and satisfactory certificate of the death" is a prerequisite for issuance of the permit.[1]

In most cases death certificates are made and signed by a physician. Of course, if there was a physician attending the patient just prior to death, he has this task.[2]

In some cases, and even then only if certain conditions are met, the local registrar is a competent person to make and sign the certificate of death. In others, in the presence of a different set of conditions, the county coroner is competent.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

(1) There had been no attending physician;

(2) The person desiring to dispose of the body has made request for a burial or removal permit; and

(3) It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough for the purpose."[3]

"Early enough for the purpose" has not received official interpretation, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. With all three conditions fulfilled, the registrar may make and sign the certificate, incorporating information supplied by relatives of the deceased or other competent lay persons.[4] If a physician *may* be obtained he *must* be obtained, and his services paid for by the person seeking disposition of the body. Such payment is reimbursable from the estate of the deceased person as a proper funeral expense. See 40 O.A.G. (1951) 476.

The circumstances permitting issuance of a certificate of death over the signature of a coroner are more numerous. In any case, where he has held an inquest on the body, the coroner is competent to execute the certificate. Or, without formal inquest, if he has investigated a death falling in any of nine specific categories, he is similarly competent. These are:

(1) Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like;

(2) Death under unexplained, unusual, or suspicious circumstances;

(3) Homicide;

(4) Suicide;

(5) Death following an abortion;

(6) Death due to poisoning, whether homicidal, suicidal, or accidental;

(7) Death following accident, whether the injury received was the primary cause of death or not;

(8) Death when no physician was in attendance; and

(9) Death when a physician refuses to sign the death certificate.[5]

It is to be noted that whoever makes and signs a death certificate must be acquainted with the facts. The attending physician, of course, will as a rule find it unnecessary to make a special investigation in order to prepare the certificate. A physician especially called to prepare the certificate will,

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[1] See Section 69.44 (1) of the Wisconsin Statutes.

[2] Section 69.38 of the Wisconsin Statutes reads as follows:

"Physician's certificate, causes of death. (1) The certificate of death shall be made and signed by the physician last in attendance on the deceased and shall specify the time in attendance, the time he last saw the deceased alive, and the hour and the day at which death occurred.

(2) He shall state the causes of death so as to show the course of disease or sequence of causes resulting in death, and the duration of each.

(3) Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from diseases are not sufficient for issuing a burial or removal permit and any certificate containing only such terms shall be returned to the physician for correction and definition.

(4) Causes of death which may be the result of either disease or violence shall be carefully defined, and, if from violence, its nature shall be stated, and whether accidental, suicidal, or homicidal.

(5) In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required under this head and shall state where, in his opinion, the disease was contracted.

(6) And the cause of death and all other facts required shall in all cases be stated in accordance with the rules and regulations of the state registrar."

[3] Section 69.39 of the statutes.

[4] Section 69.40 of the statutes.

[5] Until recently the coroner could make and sign a death certificate only if he had held an inquest. This was provided for by Section 69.41 of the statutes. But this section has been amended by Chapter 97 of the Session Laws of 1955, to permit the coroner to act following an investigation of any death such as referred to in Section 366.20 of the statutes, where the nine categories are to be found.

on the other hand, not undertake to insert the specific information required without first making whatever investigation he deems necessary. The local registrar, when he is competent to act, may rely on information provided by lay persons, but only where prompt action is necessary and a physician may not be obtained. In the special situations in which the coroner may act, either a formal inquest or other investigation by him is necessary.

For a more complete and detailed analysis of the Wisconsin Statutes specifying who may make and sign death certificates, the opinion of the Wisconsin Attorney General in 40 O.A.G. 476 may be consulted. This opinion, written in reply to an inquiry by Dr. Carl N. Neupert, State Health Officer, was issued on December 7, 1951. Since then, the statutes have undergone amendments which render the opinion partially obsolete, especially as regards coroners. The opinion, however, is still valid as regards local registrars. Moreover, the general approach taken in the opinion is still appropriate. In that approach, the attorney general recognized that the attending physician is normally the person to make and sign a death certificate. All others are exceptions to the rule; and, therefore, they may not legally serve, without fulfilling to the letter, the statutory requirements on which their competence is based.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.10 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event, may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of not less than one hundred dollars ($100.00), or imprisonment in a county jail for not to exceed six months.

EMPLOYERS OF FOUR OR MORE SUBJECT TO UNEMPLOYMENT INSURANCE TAX

As of January 1, 1956, employers, including physicians, who employ *four or more* persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to *both* the Wisconsin and Federal Unemployment Insurance Tax.

The combined state and federal tax is 3% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.3% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

Just as soon as an employer has employed four or more persons in any portion of each of 20 weeks he should notify the Unemployment Compensation Division, 137 East Wilson Street, Madison, in order that prompt payment may be made of taxes owing from the beginning of the year. At the same time, he should request appropriate forms from the Director of Internal Revenue, Milwaukee.

Some physicians and others have indicated they plan to substitute a full-time employee for two part-time employees—and thus keep below the four-employee level. It is possible to place part-time bookkeepers who work independently without direct supervision on a fixed fee basis, and thus make them independent contractors rather than employees. The status of professional employees could be changed to that of partners as another means of keeping under the level of four employees.

If any of the above plans are to be used, they should be carefully scrutinized by an attorney and should be in effect *before* May 1, 1956.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes

1. By January 15, 1956, you must pay the final installment of the estimated federal tax on your 1955 income. This may necessitate an amended declaration by that date if you find that you underestimated 1955 income. A final income tax return for 1955, filed before January 31, 1956, will be treated as the equivalent of an amended declaration as of January 15. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.

2. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1955 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1955.
   (3) File fourth quarterly return for 1955 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1955.
   (4) Pay income and social security taxes withheld on 1955 wages of employees if:
      (a) More than $100 was withheld in December, 1955, and not paid to government depositary earlier in January, 1956; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1955.

3. Miscellaneous:
   (1) If the total of income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on Form 941 should be filed on or before the tenth of February, May, August and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1956, for the respective preceding calendar quarters.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.

4. File your Wisconsin and federal partnership and personal income tax returns as early in 1956 as possible, but no later than April 15.

5. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1956 income must be shown on a federal declaration form which has to be filed, together with the estimated tax due, by April 15, 1956. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1956. As to the final payment or amendment of declaration due in January, 1957, follow the alternative procedure described in Section 1 above.

   Excluding cases of wilful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1956 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1956. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license and basic science certificate with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the mentally ill. Sec. 51.01 (2) (a) statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate. See page 61 of this issue.

Federal and Wisconsin Unemployment Compensation Liability.

See in this connection the text of the box on page 62 of this issue.

EPILEPTICS AND THE STATE MOTOR VEHICLE DEPARTMENT

Epileptics have been removed from the category of persons deemed mentally ill by Chapters 457 and 534 of the Wisconsin Session Laws, as enacted during the 1955 legislature. Nevertheless, the law governing the issuance of drivers' licenses to epileptics remains unchanged. No one who is subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin, except under the following conditions:

If an epileptic is under medical care, however, and while under medication is free from seizures, and his driving is not otherwise a hazard to public safety, he may be issued a temporary license, which must be recertified each six months. Section 85.08 (6) (j) of the Wisconsin Statutes, enacted during the 1949 session of the Legislature, provides that any physician licensed in this state may recommend such a temporary license for a patient on a combined questionnaire and recommendation form provided by the Motor Vehicle Department.

The issuance of a temporary license, predicated upon such a recommendation by the physician rendering treatment, is discretionary with the Motor Vehicle Department, but a denial may be reviewed by a special board, two of the three members of which are designated by the president of the State Board of Health.

CHEMICAL TESTS FOR INTOXICATION

The 1955 Wisconsin Legislature has created a new statute on chemical tests for intoxication, which may be of interest to physicians. Section 325.235 of the statutes authorizes the use of analyses of samples of breath, blood, urine or saliva in court cases and other legal proceedings where the sobriety of a person operating a vehicle or handling a firearm is in issue. It also sets up standards for the interpretation of the resulting data as evidence.

Sobriety will be deemed proved, unless there is other evidence to the contrary, if a sample taken within two hours of the event shows only 5 one-hundredths of 1% or less by weight of alcohol in the blood. Intoxication will be presumed, in the absence of contrary evidence, if the alcohol concentration is 15 one-hundredths of 1% or more. Concentrations between these two ratios create no presumption, and the same is true if the sample was taken more than two hours after the event, unless an expert witness testifies as to what the test proves.

University Hospitals

THE State of Wisconsin directed the establishment of its General Hospital in Madison primarily to furnish facilities for teaching and the advancement of medical knowledge and to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities. As these purposes have been carried out, there has developed a group of interrelated facilities known as the University Hospitals and including these specific units:

The State of Wisconsin General Hospital, which is the major unit and in which are the service areas for all the hospitals.

The Mary Cornelia Bradley Memorial Hospital, the pediatric section of the hospitals.

Cancer Research Hospital, an integral part of the State of Wisconsin General Hospital in which also are located some of the laboratories and out-patient clinics devoted to cancer patients.

The Wisconsin Orthopedic Hospital for Children, administered in cooperation with the Crippled Children's Bureau of the State Department of Education.

The Student Infirmary, in which the Health Clinic and facilities for services to University students are located.

These units together provide 900 beds under central administration and are departmentalized to meet the clinical teaching needs of the Medical School.

The Regents of the University administer the hospitals, which are expected to be self-supported by fees for services rendered.

The hospitals are staffed by the faculty of the Medical School.

Provision is made for residents of the counties of the state who cannot pay for this care, as well as for those who are able to.

All patients coming to the hospital are expected to be referred by their family physician, to whose care they are returned after discharge from the hospital.

Public patients: These patients are admitted with the approval of the judge of their county of residence, upon his determination of their need for care and their inability to pay for it. They are paid for jointly by their county of residence and the state. To avoid inequities, especially for the counties with less facilities, a quota of two patients per thousand of population has been established; if the quota is exceeded, the county bears the entire cost of care. The state may collect for hospital services if during the ten-year period following the services, the patient's financial situation changes so that he can pay for them.

Special rate patients: This classification was established to assist the family physician in providing for his patients the unusual diagnostic and treatment facilities usually associated with a teaching hospital. The patient is referred by his physician to the hospital for diagnosis, for treatment, or both, and with the certification that hospital charges can be paid by the patient but that professional fees in addition will be a hardship. This classification is also used for patients referred by public agencies to whom the public patient status is not available.

Charges for the above two types of patients are on an inclusive basis, and presently are at the rate of $20.00 per day.

Private patients: Provision is made for a small number of private patients. No more than 20% are permitted. They are referred directly by their fam-

ily physician to staff members having private patient consultation privileges. Private patients pay the hospital charges and, in addition, charges for laboratory and x-ray examination, operating room charges, charges for special drugs, and the professional fees of the staff members who care for them.

The hospital bed charge only for this type of patient is $20.00 per day. Similar types of patients are also provided for in the Orthopedic Hospital, where public patients, orthopedic and plastic surgery cases, are admitted with the approval of the Bureau of Crippled Children. Liability for repayment of services rendered does not exist in this hospital.

Charges in the Orthopedic Hospital are presently $16.00 per day for public patients and $17.50 for special rate and private patients.

Veterans: Special provision is made for veterans who have lived in Wisconsin for five years prior to admission and who present their certificate of honorable discharge. They may be admitted to the hospital at an inclusive rate of $5.90 per day, or they may be admitted as private patients with the responsibility for professional fees in addition to the hospital charge of $5.90 per day.

Out-Patient Department

The hospitals also provide out-patient clinic services in all the various departments. The necessity for referral by the family physician also obtains here; and because the clinics do not operate each day, prior arrangements are necessary.

Out-patient registration charges, paid by *new* patients only are presently $1.00 for the public patient and $5.00 for either special rate or private patients. Special laboratory and x-ray charges are made where indicated, and the private patient is also responsible for professional fees.

For further information, write or phone:

Superintendent
University Hospitals
1300 University Avenue
Madison, Wisconsin
Alpine 6-6811

PHYSICIANS ADVISED ON SUBSTITUTION OF SILVER NITRATE

Attention has been directed to the fact that some Wisconsin physicians are reporting on birth certificates the use of penicillin as a substitute for silver nitrate in the prevention of opthalmia neonatorum. While there has been some discussion in professional circles regarding the efficacy of substitutions for silver nitrate, the Committee on Maternal and Child Welfare has expressed the opinion that to date there is insufficient evidence to support such action. Physicians are urged to subscribe to the procedures clearly set forth in the Wisconsin Statutes, which reads:

> "146.01 Infant Blindness: (1) For the prevention of opthalmia neonatorum, or blindness in the new born babe, the state board of health shall, annually, cause to be prepared and put up in proper containers a one per cent solution of nitrate of silver with instructions for its use. These shall be distributed free to local health officers in quantities sufficient to enable them to, and they shall, deliver one to each physician and midwife. The attending physician or midwife shall use the said solution as directed in said instructions.
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> * * *
>
> "(3) Any person who violates this section shall be fined not more than one hundred dollars."

On the basis of present procedures set up through the State Board of Health, and the reliable services of the State Laboratory of Hygiene in supplying solutions of correct strength and freshness, it does not appear advisable to the Committee on Maternal and Child Welfare to suggest revision of the Wisconsin statutes at the present time.

Until such time as the wording of the law is changed, physicians are warned to avoid the use of any substitute for silver nitrate in the prevention of opthalmia neonatorum, as violation of the statutes subjects a physician to a possible fine, as indicated, and may subject him to a suit for malpractice.

The position adopted by the committee concurs with that of the American Medical Association as was stated in an editorial which appeared on page 123 of the January 12, 1952, edition of the Journal of the American Medical Association.

Instructions for the Use of Wisconsin State Laboratory of Hygiene

University of Wisconsin—Laboratory of the State Board of Health

Location of Laboratory

State Laboratory of Hygiene Building, 437 Henry Mall, Madison 6, Wisconsin

Working Hours

Monday through Saturday—7:45 a.m. to 4:30 p.m.
Sundays—8:30 a.m. to 12 noon
Holidays—7:45 a.m. to 12 noon

Telephone—Alpine 6-6811, Extension 511 or Extension 513.

General Information

Submitting Specimens: The value of a laboratory examination depends as much on the quality of the specimen as upon technic in the laboratory. A poorly collected and improperly prepared specimen cannot be expected to yield reliable information. Physicians, health officers, nurses, medical technologists, sanitarians, sanitary engineers, and veterinarians are therefore urgently requested to see that every specimen sent to the laboratory is collected according to the instructions furnished with the specimen outfits. They should complete the specimen information blank in the outfit, including the exact information desired and a very brief clinical history if indicated. This blank is to be enclosed with the freshly collected specimen in the mailing case and the entire outfit mailed promptly.

WRITE PLAINLY to insure accuracy in transcribing the name of the patient as well as the name and address of the sender. The importance of a legibly filled-in form cannot be overemphasized. Printed or typewritten information is desirable.

The use of **antibiotic therapy** before collecting specimens for culture may result in the inability of the laboratory to isolate the causative agent. If specimens are submitted after treatment with antibiotics, a statement to that effect should be made on the data sheet, naming the antibiotic used.

Specimens should be submitted PROMPTLY after collection.

Mail Service and Postage Rates on Specimens: Federal laws require that all material of this nature sent through the mail must be packed in double mailing containers in an inside tin and an outside mailing carton.

Specimens submitted in the outfits provided by the State Laboratory of Hygiene and accompanied by the regulation data sheets may be mailed at fourth-class postage rates (parcel post), PROVIDED no communication other than that called for on the data sheet is included. Postage and express charges must be paid by the sender.

WEEK-END SERVICE. Specimens mailed to the laboratory either Friday or Saturday may remain in the post office over Sunday. In order to avoid spoilage and hemolysis, blood specimens should be sent by special delivery or refrigerated until they are mailed. This precaution is especially important during hot or very cold weather.

Mailing containers, which are sent free upon request, are expensive; and only those necessary for short periods of time should be requested. They should be used only for returning specimens to this laboratory for examination.

Laboratory Records and Reports: LABORATORY RECORDS ARE CONFIDENTIAL. No information is given except upon receipt of written permission from the sender of the specimen.

Reports by wire are sent collect and only upon request. This request may be written on the data sheet, provided first-class postage is used on the package. Reports on certain examinations are usually mailed within 12 to 24 hours from the time the specimen is received. Cultures require more time, and occasional preliminary reports are sent.

The Interpretation of Laboratory Findings: The laboratory test serves to supplement, and sometimes confirm, clinical observations. At times a positive laboratory finding may be conclusive; but there are many conditions in which it may not be, and such interpretation should be made with caution. Negative findings should not be accepted as conclusive. Additional specimens should be submitted when the laboratory findings are doubtful or questionable. In establishing the etiology of certain communicable diseases, the demonstration of a definite rise in antibody titer (by agglutination or complement fixation tests) is of more significance than the results of the test on a single sample of blood. For this reason, two samples of blood—acute phase and convalescent phase—should be submitted in suspected cases of virus and rickettsial diseases.

SEND FOR GUIDE

Copies of the complete guide for submitting specimens, and instructions for use of the laboratory are available without cost upon request to the laboratory, 437 Henry Mall, Madison 6, Wisconsin. Special outfits for securing specimens are also available upon request.

Officers of State Boards and Commissions

State Board of Health

Members of the Board

Stephen E. Gavin, M. D., President, Fond du Lac, 1957
Samuel L. Henke, M. D., Vice-President, Eau Claire, 1960
Carl N. Neupert, M. D., M.S.P.H., Secretary, Madison
William T. Clark, M. D., Janesville, 1956
Carl D. Neidhold, M. D., Appleton, 1959
Forrester Raine, M. D., Milwaukee, 1961
John S. Hollingsworth, D. D. S., Sheboygan, 1958
Joseph C. Griffith, M. D., Milwaukee, 1962

Bureaus, Divisions, and Units of State Board of Health

Carl N. Neupert, M. D., M.S.P.H., State Health Officer
E. H. Jorris, M. D., M.S.P.H., Assistant State Health Officer

Section on General Administration

E. H. Jorris, M. D., M.S.P.H., Director
Division of Staff Services—E. H. Jorris, M. D., M.S.P.H., Director
Division of Personnel—Henry Kjentvet, B.S., Director
Division of Statistical Services—Vivian B. Holland, M.S.P.H., Statistician
Division of Fiscal Services—Fred E. Brown, Ph. B., C.P.A., Director
Division of Internal Services—Lenore Brandon, Supervisor
Division of Laboratories—W. D. Stovall, M. D., Director
Bureau of Vital Statistics—Paul Weis, Assistant State Registrar
Division of Dental Education—Francis A. Bull, D. D. S., M.S.P.H., Director
Division of Health Education—Philip Dykstra, B. A., Director
Division of Hospital and Related Services—Vincent F. Otis, Director
Division of Cosmetology—Kathleen Bower, Supervisor
Division of Barbering—Thomas D. Ritchie, Supervisor
Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor
Division of Hotels and Restaurants—Harold E. Olsen, Ph. B., Supervisor

Section on Preventable Diseases

Milton Feig, M. D., M. P. H., Director
Bureau of Communicable Diseases—Milton Feig, M. D., M. P. H., Director
Division of Tuberculosis Control—Milton Feig, M. D., Acting Director
Division of Venereal Disease Control—A. L. Van Duser, M. D., M. P. H., Director
Division of Cancer Control—A. L. Van Duser, M. D., M. P. H., Director
Division of Heart Disease Control—Milton Feig, M. D., Acting Director

Section on Environmental Sanitation

O. J. Muegge, M. S.—State Sanitary Engineer
Harvey Wirth, B. S.—Assistant State Sanitary Engineer
Bureau of Sanitary Engineering—Harvey Wirth, B. S., Director
Division of Plumbing—Walter Spencer, Supervisor
Division of Well Drilling—Thomas Calabresa, M. S., Supervisor
Division of Rendering and Slaughtering—Harold L. Johnson, Supervisor
Division of Water Pollution Control—T. F. Wisniewski, B. S., Director

Section on Maternal and Child Health

Amy Louise Hunter, M. D., Dr. P. H., Director
Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Dr. P. H., Director
Division of Child Guidance—Vacancy
Division of Nutrition—Lucile K. Billington, M. S., Supervisor

Section on Local Health Administration

Allan Filek, M. D., M. S. P. H., Director
Bureau of Public Health Nursing—Janet Jennings, R. N., M. A., Director
Division of Industrial Hygiene—William L. Lea, Ph. D., Director
Division of Local Health Administration—Allan Filek, M. D., M. S. P. H., Director

District Health Offices

No. 1—602 Insurance Building; Phone Alpine 6-4411, Extensions 2248 and 2249, Madison

No. 2—9 West Walworth, Phone Parkview 3-3223, Elkhorn

No. 3—146 Forest Avenue; Phone 4055, Fond du Lac

No. 4—P. O. Box 251; 114½ South Water Street, Phone 566, Sparta

No. 5—City Hall, P. O. Box 270; Phone 685, Wisconsin Rapids

No. 6—1136 West Mason Street, Box 383; Phone Hemlock 2-1322, Green Bay
No. 7—417½ North Bridge Street; Phone Park 3-6642, Chippewa Falls
No. 8—City Hall; Phone 308, Rhinelander

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies; reorganized by act of 1949 legislature.)

Members of the Board

William H. Studley, M. D., Milwaukee, 1959
Mr. Harold W. Story, vice-chairman, Milwaukee, 1957
Mrs. Harrison L. Garner, Madison, 1959
Mr. Ralph Uihlein, Milwaukee, 1957
W. D. Stovall, M. D., chairman, Madison, 1961
Mrs. Karl Kleinpell, Cassville, 1961
Mr. Leo Jelinske, Shawano, 1961
Mr. Earl M. Hale, Eau Claire, 1959
Mrs. C. R. Beck, secretary, West Allis, 1957

Executive Staff

Mr. Wilbur J. Schmidt, Madison, Director
Mr. George M. Keith, Madison, Deputy Director

Division of Corrections
Mr. Sanger B. Powers, Madison, Director

Division of Mental Hygiene
Leslie A. Osborn, M. D., Madison, Director

Division of Public Assistance
Mr. Thomas J. Lucas, Sr., Madison, Director

Division of Business Management
Mr. Kurt J. Kasper, Madison, Director

Division for Children and Youth
Mr. Frederick DelliQuadri, Madison, Director

Basic Science Examiners

Prof. George G. Town, President, University of Wisconsin Extension Division, 623 W. State Street, Milwaukee, Wisconsin, 1959
Prof. W. H. Barber, Secretary, Ripon College, 621 Ransom Street, Ripon, Wisconsin, 1957
Prof. B. H. Kettelkamp, River Falls State College, 429 Crescent Street, River Falls, Wisconsin, 1961

State Board of Medical Examiners

Millard Tufts, M. D., President, 208 East Wisconsin Avenue, Milwaukee, 1957
J. W. McRoberts, M.D., Vice-President, 1011 North Eighth Street, Sheboygan, 1959
Thos. W. Tormey, Jr., M. D., Secretary, 1140 State Office Building, Madison, 1959
E. C. Murphy, D. O., 438 Gilbert Avenue, Eau Claire, 1957
C. A. Olson, M. D., Baldwin, 1957
E. H. Pawsat, M. D., 44 South Marr Street, Fond du Lac, 1959
F. A. Ross, M. D., 2301 North Fortieth Street, Milwaukee, 1959
J. A. Schindler, M. D., 921 Sixteenth Avenue, Monroe, 1957

Wisconsin Industrial Commission

Members of the Commission

Mr. R. G. Knutson, Chairman, 1957
Mr. A. W. Enright, 1959
Mr. John H. Rouse, 1961
Miss Helen E. Gill, Secretary

Workmen's Compensation Department
Mr. Harry A. Nelson, Director

Unemployment Compensation Department
Mr. Paul R. Raushenbush, Director

Safety and Building Department
Mr. Roger Ostrem, Director

Woman and Child Labor Department
Maud Swett, Director

State Board of Vocational and Adult Education

E. J. Fransway, Employee member, 1957 _Milwaukee
Mrs. Erna Cartwright,
Employee member, 1959 _____Oshkosh
Frank C. Horyza, Employee member, 1959 _Superior
Alfred A. Laun, Employer member, 1959 _____Kiel
W. C. Van Cleaf,
Employer member, 1961 _____Milwaukee
Morton Frost, Employer member, 1957 ____Kenosha
John Last, Farmer member, 1961 _____Lake Mills
T. E. Hamilton, Farmer member, 1957 ____Westfield
Elmer Wilkins, Farmer member, 1961 ____Platteville
G. E. Watson, ex officio _____Madison
R. G. Knutson, ex officio _____Madison
C. L. Greiber, ex officio _____Madison

State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Office

Room 320, State Office Building, Madison

John A. Kubiak_____Chief
J. H. Brown_____Assistant Chief
Charles Beardsley
_____Guidance, Training and Placement
Irene M. Dunn_Finances and Mentally Handicapped
A. E. Towne_____Medical Service
Mrs. Mary F. Beyer_____Homecraft
Edward J. Pfeifer_____Psychological Service
Milton Feig, M. D.
_____Medical Administrative Consultant (State Board of Health)

Mrs. Inez F. Belyea
Social Work Supervisor (Medical)
Mrs. Thelma Peckham—Statistician

District Offices

Madison—Vocational School Building, 211 North Carroll Street, Room 458
C. D. Rejahl, District Supervisor
Milwaukee Vocational School Building, 1015 North Sixth Street, Room 222
L. A. Rumsey, District Supervisor
Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor
Eau Claire—8½ South Farwell Street
Melvin J. Chada, District Supervisor

Local Offices

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor
Racine—828 Center Street
V. C. Bryan, Case Supervisor
Wausau Vocational School Building
L. J. Schultz, Case Supervisor
Superior—917 Tower Avenue
Howard L. Haralson, Case Supervisor

DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS

R. G. Piaskoski, M. D.—Milwaukee
P. J. Collopy, M. D.—Milwaukee
E. P. Roemer, M. D.—Madison
J. G. Beck, M. D.—Sturgeon Bay
C. C. Gascoigne, M. D.—Kohler

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1956 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify number of forms wanted and for which clinic they are wanted. Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

Location	*Date*
Ashland	February 15, 16
Manitowoc	February 23, 24
Green Bay	March 1
	March 2
Kenosha	March 7
	March 8
Eau Claire	March 15, 16
Racine	March 21, 22
Wausau	March 28, 29
Superior	April 5, 6
Sheboygan	April 11, 12
Marinette	April 18
La Crosse	April 24, 25
	April 26, 27
Appleton	May 10, 11
Fond du Lac	May 16
Chippewa Falls	May 23, 24
Rhinelander	June 5, 6
Lancaster	July 19
Darlington	July 20
Eau Claire	July 26, 27

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

Benefit Programs of the W.I.A.A.

THE Wisconsin Interscholastic Athletic Association has been a guardian of student health and safety in competitive athletics for many years. Through its programs, there has been a gradual increase in the excellency of coaching and supervision in athletics, the development of numerous important safety devices, and the promotion of well-regulated interscholastic athletics on both the high school and grade school levels. Incidental to these purposes, but nevertheless a major part of the W.I.A.A. activity, has been the development of accident benefit programs to provide enrolled pupils and athletes with certain indemnity benefits to assist in meeting the cost of medical and dental care in event of accidental injury.

Two committees of the State Medical Society of Wisconsin advise with the W.I.A.A. The subcommittee on W.I.A.A. of the Division on School Health of the Commission on State Departments serves to advise the W.I.A.A. Board on matters relating to health and medical regulations. The Commission on Prepaid Plans of the State Medical Society advises the W.I.A.A. with regard to the payment of claims and the schedule of medical and surgical allowances. The close liaison of the W.I.A.A. with the State Medical Society has resulted in a steadily improving program for schools, pupils, and those who provide health services.

Four Types of Plans

Basically, the W.I.A.A. offers four types of accident benefit plans:

1. Pupil Accident Benefit Plan, providing indemnity benefits for care of injuries sustained while the pupil is at school or under the direction and supervision of the school. This covers injuries sustained in intramural competition but not injuries sustained in interscholastic athletic competition.

2. Individual Accident Benefit Plan, providing indemnity benefits for students who may be injured while preparing for or participating in interscholastic athletic competition.

3. Group Athletic Accident Benefit Plan, providing group rates for interscholastic athletic-type coverage to those who are also covered under the Pupil Accident Benefit Plan for other school injuries.

4. Summer Sports Program, providing coverage of participants in summer playground, recreation, and sports programs approved by the W.I.A.A. Approved programs are those supported in whole or in part by public taxation, and American Legion baseball.

Under each of the four programs, benefits are not provided for cases resulting from congenital weaknesses or from violations of required safeguards, nor when safety measures are disregarded. The benefit plans do not provide indemnity for the following items: hernia; boils; skin infections; recurrent dislocations; athlete's foot; broken glasses; orthopedic appliances; medicines and bandages; ambulance service; and injuries resulting from epilepsy, fits, convulsions, diabetes, or any congenital weakness.

If an injury occurs in an interschool game, benefits will be paid only if the game officials in charge are registered with the W.I.A.A.

Medical Regulations

Medical regulations developed in cooperation with the State Medical Society advisory committees have been set up for all types of coverage. These medical regulations are as follows:

1. Payments for benefit requests will be authorized only when the medical and surgical aid given to the injured person is rendered by a licensed physician, that is, a doctor of medicine and surgery or a doctor of osteopathy and surgery.

2. A person or institution rendering service shall mail immediately the Authorization for Treatment to the W.I.A.A. Benefit claims for the participant are validated only when the school's preliminary report and/or the authorization of treatment is postmarked within 21 days of the date of injury and the claimant receives treatment by a qualified physician or surgeon within 21 days of injury.

3. Payments for consultation and referral services will be authorized only when requested by the original physician and so indicated in his statement.

4. The fees for fractures and dislocations include charges for pre- and postoperative care, reduction, and fixation but are exclusive of the hospital allowance and x-ray fees. Joint separation will be classed as a dislocation. Epiphyseal separation will be interpreted to be a break. The maximum allowance for all x-rays shall not exceed the scheduled x-ray benefit.

5. When surgery is required in connection with medical attendance, an additional allowance not to exceed $25.00 will be provided when approved by the Medical Advisor.

6. Multiple Injuries. When an accident involves injury to more than one part of a person's body, the indemnity will be that for the major injury plus 50% of the fee for each other injury.

7. The scheduled indemnity is the maximum in each case. The amount actually allowed will not exceed the itemized statement filed by the physician. Local practice shall determine the fees for treatment.

8. (Does not apply to coverage under the Pupil Accident Plan.) Benefit claims, except broken teeth and negative x-ray cases, will be valid and compensable only when the athlete remains out of all athletic activity, including practice and games, for the number of days indicated in the schedule given on page 72.

	Fractures			Dislocations			
	No Reduction	Closed Reduction	Open Reduction	No Reduction	Closed Reduction	Open Reduction	X-ray Allowance
1. Ankle joint (one or all malleoli)	$ 25.00	$ 60.00	$ 90.00	$ 10.00	$ 35.00	$100.00	$ 5.00
2a. Clavicle	15.00	25.00	50.00				5.00
b. Inner Joint				25.00	25.00	75.00	5.00
c. Lateral Joint				15.00	50.00	75.00	5.00
3. Coccyx	15.00	25.00	50.00				10.00
4. Colles'—Radius, Ulna	20.00	50.00	75.00				5.00
5a. Elbow—T Fracture	35.00	75.00	100.00		35.00		5.00
b. Medial Epicondyle	20.00	35.00	75.00				5.00
c. Lateral Condyle	20.00	35.00	75.00				5.00
d. Radial Head	20.00	35.00	75.00				5.00
6. Femur (shaft)	40.00	100.00	135.00				10.00
7a. Forearm—Radius (shaft only)	20.00	50.00	75.00				5.00
b. Ulna (shaft only)	20.00	50.00	75.00				5.00
c. Radius and Ulna Shaft	30.00	60.00	100.00				5.00
8a. Hip—Intertrochanteric	40.00	100.00	150.00		60.00	75.00	10.00
b. Intracapsular	40.00	100.00	150.00		60.00	75.00	10.00
9. Humerus	35.00	50.00	100.00				5.00
10. Maxilla—Inferior, Superior, or Zygomatic	32.50	70.00	95.00		10.00		10.00
11. Metatarsal—Single	10.00	20.00	30.00		25.00	40.00	5.00
Each Additional	3.00	5.00	12.50		20.00	30.00	
12. Nose	10.00	25.00	75.00				5.00
13. Patella	20.00	25.00	110.00				5.00
(semilunar cartilage)				15.00	25.00	100.00	5.00
14. Pelvis	30.00	60.00	100.00		60.00	150.00	10.00
15. Rib (one or more)	15.00	15.00					10.00
16. Scapula	15.00	50.00	100.00				10.00
Shoulder					25.00	75.00	10.00
17. Skull and/or Cerebral Hemorrhage		50.00	100.00				10.00
Skull—No Cerebral Damage	25.00						
18. Spine (vertebral body compression, one or more)	30.00	75.00	150.00	25.00	75.00	150.00	10.00 entire 20.00
19. Sternum	10.00	25.00	50.00				5.00
20. Tarsal Os Calcis	25.00	50.00	60.00				
21. Tarsal (excluding os calcis)	20.00	50.00	75.00		35.00	75.00	5.00
22. Tibia (involving knee joint)	30.00	75.00	110.00				5.00
23. Tibia or Fibula Shaft or Both	25.00	60.00	75.00				5.00
24a. Toe—Great	10.00	15.00	15.00				
b. Other Toe	5.00	10.00	10.00		5.00	10.00	5.00
c. Each Additional	3.00	5.00	5.00		5.00	10.00	
25. Transverse	10.00	10.00					10.00
26a. Wrist and Hand—Carpal	25.00	25.00			35.00	75.00	5.00
b. Metacarpal (single)	10.00	20.00	25.00		15.00	25.00	5.00
c. (each additional)	3.00	5.00	10.00		10.00	10.00	
d. Finger	5.00	15.00	25.00		5.00	15.00	5.00
e. (each additional)	3.00	5.00	10.00		5.00	10.00	

For all injuries requiring an absence of twelve (12) days or more subsequent benefits will be authorized only if the attending physician certifies that he had re-examined and pronounced the athlete physically fit before the athlete returned to competition.

	Required Reduction	No Reduction
A. Aspirations, Cuts, Medical Attendance, and all others		5 days
B. Broken nose, hand, foot, rib, or dislocated fingers	12 days	6 days
C. Broken Bones (excepting those specified in B)	60 days	30 days
D. Dislocation or separation of joint	30 days	15 days
E. Injuries to knee, involving bony joint proper and/or internal or external cruciate ligament	60 days	60 days
F. Injuries to kidneys—contusion		30 days
Injuries to kidneys—developing hemorrhage, albuminuria, or evidence of cellular structure in urine	1 year	
G. Rupture of viscus requiring surgery	1 year	
H. Skull injuries (concussion with hemorrhage)	1 year	1 year
(Minor concussion—no hemorrhage)		30 days

9. Matters of arbitration will be considered by the Wisconsin Interscholastic Athletic Association's Board of Control and the State Medical Society's Advisory Committee. The attending physician's records and x-ray plates as they pertain to the benefit claim in question shall be available to the arbitration committee.

10. The Board of Control reserves the right to ask for evidence beyond that originally submitted when the Advisor and the Board of Control deem such evidence desirable or necessary to establish the validity of the claim.

11. A benefit request is closed and will not be reopened if the indemnity check for the claim has been presented for payment.

Schedule of Allowances

The maximum allowance for any accident is only that which is provided in the Schedule of Allowances. All checks will be made payable to the physician, hospital, or dentist. The chart on the previous page and the following listing give the Schedule of Allowances which applies to W.I.A.A. coverage:

Miscellaneous

Entire sight of one eye if irrevocably lost	$200.00
Partial loss of sight of one eye (seriously handicapped)	100.00
Concussion (only if loss of consciousness)	20.00
Injury to viscus requiring surgery	150.00
Suture of laceration (An additional $1.00 will be allowed for each suture over one)	5.00
Lacerations (not requiring sutures)	5.00
Tetanus antitoxin	3.00
Sprains—	
Joints of hands or foot	5.00
Joints of wrist, shoulder, ankle, knee, elbow, back	10.00
Abrasions	5.00
Aspirations (limit 3)	5.00
Fluoroscope Examination	3.00

Medical Attendance **Maximum $12.00**

If the injury cannot be classified under the Schedule of Allowances but requires treatment by a licensed physician or surgeon (Medical Regulation No. 1) within 21 days of injury, not including treatment on the field at the time of play or practice, an allowance will be made with the maximum of $12.00.

Hospital Benefit **Maximum $96.00**

Hospitalization benefits are allowable in connection with the following injuries: cerebral hemorrhage, concussion, fractured vertebrae, fractured leg, fractured jaw, compound fracture of the arm requiring frame and weights, knee injury requiring surgery, ruptured viscus or other serious internal injury. To be compensable the confinement must be for a period of 12 hours or more in a recognized hospital. The maximum daily allowance is $8.00, not to exceed 12 days. The maximum hospital allowance is limited to $96.00.

Serious Injury Provision **Maximum $500.00**

If the expense incurred for necessary medical and dental care exceeds by one hundred dollars ($100.00) the benefit for the injury as provided in the schedule of allowances, the Wisconsin Interscholastic Athletic Association will pay the amount in excess of the above $100.00. The total amount of the payment by the Wisconsin Interscholastic Athletic Association for injuries resulting from one accident shall not exceed $500.00. (The principal sum will be in addition in case of death.)

Principal Sum **Maximum $500.00**

The principal sum or death benefit shall be $500.00. In order to qualify for this benefit, evidence must definitely establish that the death was directly attributed to the accident; that the death occurred within ninety (90) days of the date of accidental injury; and that there had been fulfillment of all the requirements.

"Full Coverage" and Safety Promotion Programs

The W.I.A.A. has been experimenting with a "full coverage" program for injuries sustained in athletics. Some 45,000 children have been covered during the school year 1955–1956 under a plan by which the "actually necessary expenses" for medical treatment and hospital care are paid as presented and approved by the W.I.A.A. Board up to a maximum of $2,000 for any one injury. This is an experimental effort, the results of which will determine its continuation.

During 1955–1956, the W.I.A.A. is also conducting two safety promotion programs. One of them involves 8,000 boys in 303 schools who have been testing various types of masks which are attached to football helmets for the protection of the face, particularly the teeth and nose, during football games.

The other test involves the use of canvas shoes with rubber soles in football in the hope of reducing injuries which have been traced to plastic or metal cleats attached to ordinary leather football shoes. The results of both studies will be reported after the 1955–1956 school season.

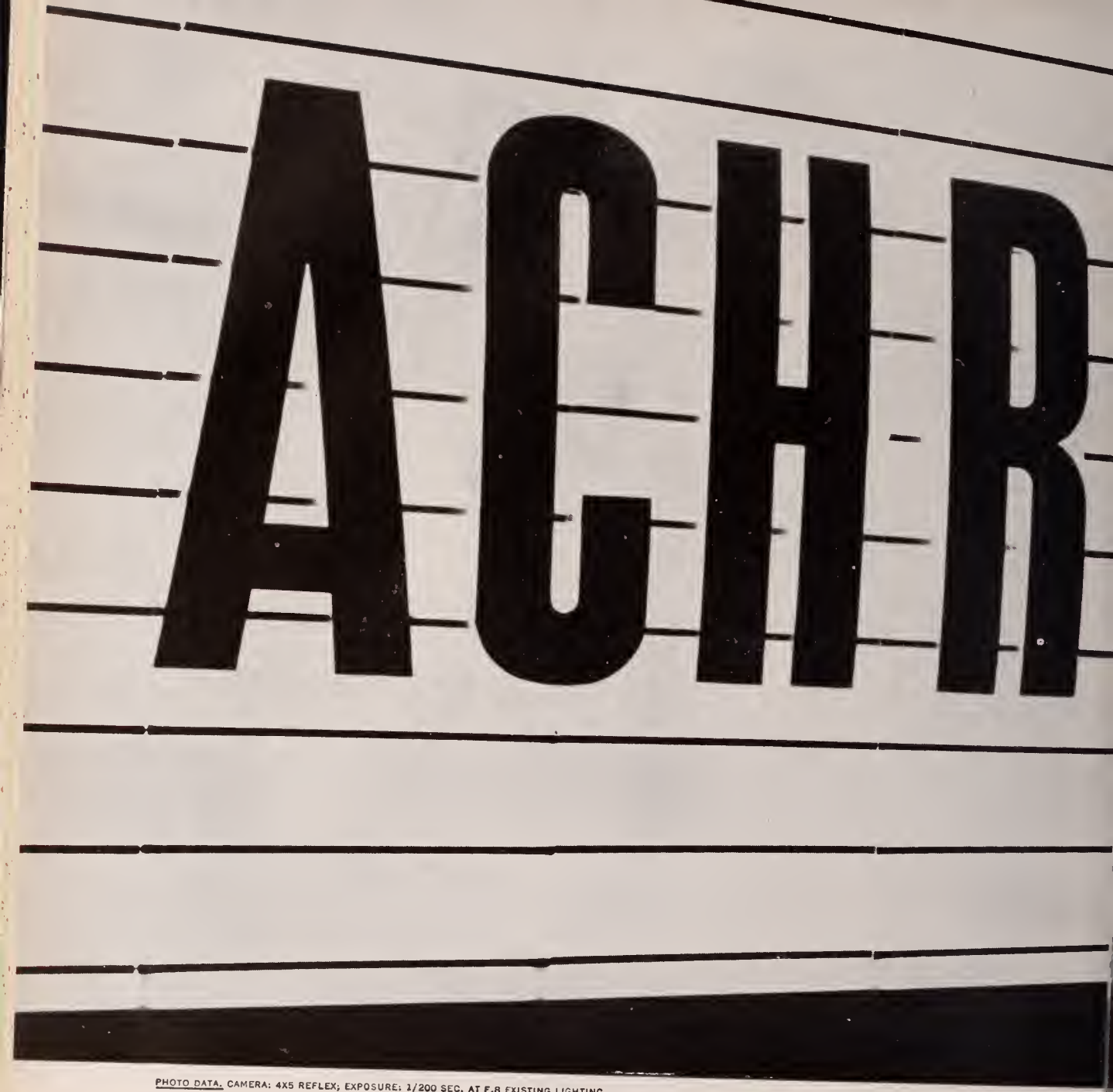
INTERNATIONAL ACADEMY OF PROCTOLOGY
8TH ANNUAL TEACHING SEMINAR

Dates: April 23–26, 1956

Place: The Drake, Chicago

Seminar Subject: Anorectal and colon surgery.

All physicians and their wives are invited to attend the seminar, whether or not they are affiliated with the Academy. There is no fee for attendance. The Woman's Auxiliary has planned an unusual program for the wives of the members and their guests.



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widely prescribed because of these important advantages:

1) rapid diffusion and penetration
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4) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
5) every gram produced in Lederle's *own* laboratories under rigid quality control, and offered *only* under the Lederle label
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Rehabilitation Services in Wisconsin

REHABILITATION services are available to eligible persons in Wisconsin through a program operated under the Rehabilitation Division of the State Board of Vocational and Adult Education. The program consists of special assistance to citizens who, because of physical or mental impairment, would either remain unemployable or would be employed at marginal pursuits.

Any person of working age is eligible for any necessary physical restoration services if he meets the following requirements:

1. He has a physical or mental defect which is a substantial employment handicap.
2. It is static, stationary, stable, or only slowly progressive. (Thus, acute illnesses and emergency cases are excluded.)
3. The disability can be removed or substantially reduced by treatment in a reasonable length of time.
4. He is unable to pay the full cost of the services out of his own resources.
5. The necessary services are not available from any other source.

Where eligibility and economic need are established, the following services can be provided: medical, psychiatric, and surgical examinations and treatment; hospitalization; convalescent care; dental care; nursing care; physical therapy; occupational therapy; speech therapy; prosthetic appliances; medical supplies; and drugs. Each applicant for vocational rehabilitation services is required to have a thorough medical examination before any services are provided. This examination usually is performed by his family physician and is financed by the state agency. In Wisconsin a committee of physicians advises the state agency regarding such matters of policy as professional standards, fee schedules, etc.

In providing service the Rehabilitation Division utilizes such public and private facilities as are available. In the medical area the Curative Workshops of Milwaukee, Green Bay, and Racine provide occupational and physical therapy, speech training, and other services. These workshops provide services on an outpatient basis only.

All patients are referred to the centers by the attending physician and are discharged by him upon completion of treatment. Physicians receive progress reports. Professional policies and practices are determined by medical advisory committees of the local medical societies.

The addresses of the workshops are as follows:

Curative Workshop of Green Bay, 1001 Cherry Street, Green Bay, Wisconsin.

Curative Workshop of Milwaukee, 750 North 18th Street, Milwaukee, Wisconsin.

Curative Workshop of Racine, 233 Northwestern, Racine, Wisconsin.

The only rehabilitation center in Wisconsin providing both inpatient and outpatient services is located in Madison and offers the following services:

Wisconsin Neurological Foundation, Madison

This is a 45-bed unit with private, semiprivate, and ward rooms. There are facilities available for complete diagnostic and therapeutic management of neurologic patients; a department of physical medicine; facilities for psychologic testing, vocational counseling, occupational therapy, and recreation. The service is operated by physicians and dentists with an adequately trained staff.

Physicians interested in making these services available to their patients may contact the facilities directly or through the Vocational Rehabilitation Office nearest them. Rehabilitation service is offered through the Rehabilitation Division of the State Board of Vocational and Adult Education only to persons of employable age who meet the criteria outlined above. Following is a list of district and local offices, with the name and title of the person in charge:

District 1

Madison 3—Vocational School Building, 211 North Carroll Street, Room 458. Clare D. Rejahl, District Supervisor

Local Offices:

La Crosse—Vocational School—Carl J. Haase, Case Supervisor

Racine—828 Center Street—Virgil C. Bryan, Case Supervisor

District 2

Milwaukee 3—Vocational School Building, 1015 North Sixth Street, Room 222. Leslie A. Rumsey, District Supervisor

District 3

Green Bay—Vocational School Building, 200 South Broadway. Arthur W. Bouffard, District Supervisor

Local Office:

Wausau—Vocational School Building, Box 750—Levern J. Schultz, Case Supervisor

District 4

Eau Claire—8½ South Farwell Street. Melvin J. Chada, District Supervisor

Local Office:

Superior—917 Tower Avenue, Room 11—Howard L. Haralson, Case Supervisor

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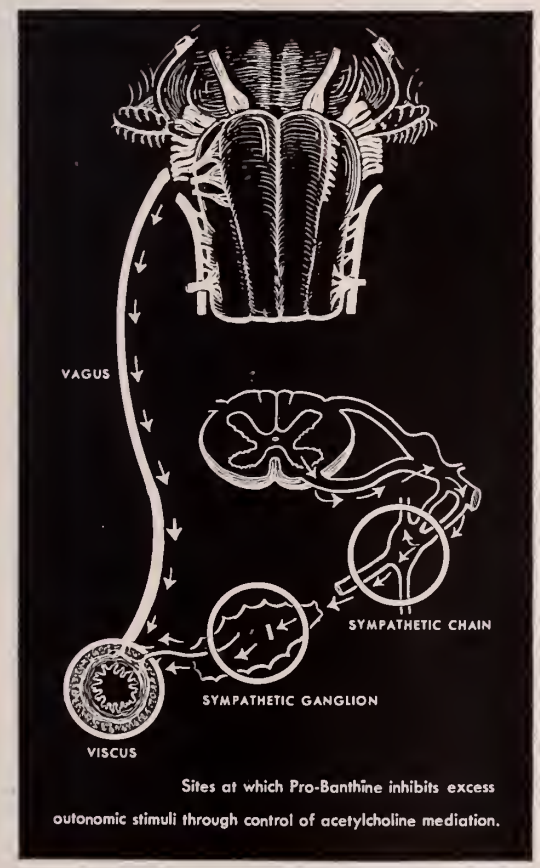
A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthine consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use[1] in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.



Sites at which Pro-Banthine inhibits excess autonomic stimuli through control of acetylcholine mediation.

Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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TB in State and County Hospitals for the Mentally Ill

Today, more than ever before, physicians realize that: (1) chronic disease may exist in persons who do not appear to be ill; (2) more than one chronic illness may be present in the same individual at the same time; (3) tuberculosis is a disease of vulnerable persons. With these thoughts in mind, may we review very briefly a few facts about tuberculosis in Wisconsin's state and county hospitals for the care of mentally ill patients.

In these 39 hospitals, over 13,000 beds are available. In 1954, 25 (or about 11.6%) of the 216 deaths from tuberculosis reported in Wisconsin occurred in mental disease hospitals. The 25 TB deaths in these institutions in 1954 represent a much higher percentage of Wisconsin's total TB deaths than did the 50 deaths in 1930. (In 1930, the 50 deaths represented 3.3% of the 1,514 TB deaths which occurred in this state.) Stated in another way, the death rate in 1954 was about 1 to 1,000 in the hospitals treating the mentally ill—assuming a population treated each year of 20,000 to 25,000—as compared with 6 to 100,000 in Wisconsin's population as a whole. In other words, the high percentage of deaths from TB in our state and county institutions represents one of the worst remaining road blocks in the pathway for the eradication of this disease in Wisconsin.

From a morbidity viewpoint, we may estimate something like 400 patients in these hospitals if the ratio of 16 patients per death is used as a measuring rod. In chest x-ray studies made in New York state mental institutions, and in comparable chest x-ray studies made in similar institutions in other states, the prevalence rate of 5% significant pulmonary tuberculosis has been demonstrated. In studies made in 1941 in Milwaukee County institutions caring for mental patients, chest x-ray films of 2,492 patients and 398 employees revealed that 235 patients and 6 employees were placed in the tuberculosis classification. Through further study, including follow-up chest films, gastric cultures, blood tests, and temperature and pulse observations, 88 definitely active cases of tuberculosis were diagnosed.

The infection rate is also believed to be high in our state and county hospitals. A majority of mental patients will probably react to the skin tuberculin test, as compared to an estimated 25% of the remainder of Wisconsin's citizens.

The reservoir of tuberculous infection and disease in this vulnerable group usually does not make its presence known until the more advanced forms of the disease have developed. The earlier stages of tuberculosis in mental patients will often surprise the physician. These patients will show a reaction to the tuberculin test. Chest x-ray shadows are evident. In those with suspicious findings by

x-ray, gastric cultures will be positive in about one-third.

We believe that about half of the estimated tuberculous cases have been detected. This group is isolated in several hospitals designated for adequate care. The remaining tuberculous mental patients are either undetected, or feel so well that those responsible for their care do not realize they have this doubly handicapped group of patients in their hospitals.

In order to accomplish the control of tuberculosis in our state and county hospitals, the Division on Tuberculosis and Chest Diseases and the Division on Nervous and Mental Diseases agree with the recommendations of the Committee on Tuberculosis in Mental Hospitals of the American Trudeau Society. These recommendations include:

1. Establish a service to direct a program for the control of tuberculosis in mental hospitals on a state-wide basis.
2. Obtain a current appraisal of the prevalence of tuberculosis by x-raying all patients and employees.
3. Provide for segregation of all active or probably active tuberculosis patients as soon as possible.
4. Establish in these isolation units medical and nursing service in accordance with modern public health and medical practice, utilizing staffs of tuberculosis centers as consultants or administrators.
5. X-ray all patients on admission and all applicants for employment.
6. X-ray periodically all patients and employees.
7. Report cases to appropriate health department.

In a few words, with the will to do; with adequate case discovery machinery, including chest x-rays and gastric cultures; and with money and personnel to carry on the program, the removal of one of the worst obstacles in Wisconsin's TB control program can be achieved.

Information, Please

Hardly a physician in Wisconsin can claim that he has not had full opportunity to be informed about the State Medical Society or the American Medical Association. Perhaps Wisconsin physicians are a little unique in that respect. One good example of such information is the recently issued report of the Wisconsin delegates to the American Medical Association meeting in Boston. This is an idea originating with the Wisconsin delegates, who for several years have used this means of expressing their special responsibility for keeping the doctor back home aware of the important actions at the annual and midyear meetings of the American Medical Association. Every doctor receives their report. Every doctor should read it. In clear, concise form, he can get the gist of the delegates' deliberations.

The report should also be an incentive to further reading. In Boston each of the delegates received one of the 328-page pocket-size books published by the A.M.A. and called the "Handbook for the House of Delegates." This book gives a graphic and varied word picture of what makes the A.M.A. tick as an organization. While not available for general distribution, these books are on loan from the office of the State Medical Society and each of Wisconsin's four delegates. The handbook is a truly fine encyclopedia of the A.M.A. and its activities.

Now that every member of the State Medical Society receives the Journal of the A.M.A., he has another opportunity to obtain the bulk of this material in the month preceding and the month following each of the A.M.A sessions. The issues of the JAMA in those months carry innumerable reports of councils, committees, and bureaus of the A.M.A., as well as detailed summaries of the actions of the House of Delegates.

Similarly, the Wisconsin physician has a real opportunity to learn of the inner workings of his State Medical Society by reading the reports of the officers and committees of the Society which are printed in *The Wisconsin Medical Journal* following the Society's Annual Meeting. Here are a complete financial picture of the Society's operations; reports on the Society's legislative, scientific, and economic accomplishments and problems; and a series of reports outlining the plans of the various committees for their activities in the coming year. As soon as the Annual Meeting of the State Medical Society is finished in May, a special report of the actions of the House is mailed to all delegates; and they, in turn, pass it on to the membership through the county society meetings.

The State Medical Society of Wisconsin makes a rather unusual effort to keep its members informed of what is going on at the state and national levels. The information is there if the physician will but read it. The doctor will not only become better informed about his State Society and the A.M.A., but he will build within himself a stronger confidence in the work being done and the policies set up to be followed. It has been said that "every branch of knowledge which a good man possesses, he may apply to some good purpose." The doctors of Wisconsin are given plenty of opportunity to obtain that knowledge. Any physician who feels that he desires more need only ask for "information, please." The officers, councilors, delegates, and staff of the State Medical Society will be only too happy to oblige.

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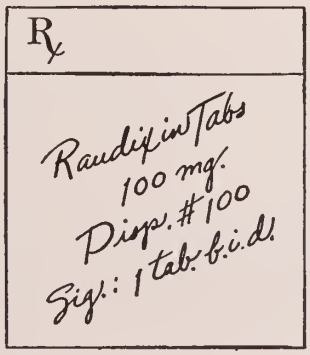

*Ataractic, from ataraxia: calmness untroubled by mental or emotional excitation. (Use of term suggested by Dr. Howard Fabing at a recent meeting of the American Psychiatric Association.)

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Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. Dr. N. A. Hill, 304 West Washington Avenue, Madison, 1958; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1957.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1958.

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Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. D. W. Carlson, 228 West College Avenue, Appleton, 1958.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 212 South 11th Street, La Crosse, 1956.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Marinette, 1956.

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Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman), Frederic, 1956.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1957.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 3333 South 27th Street, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee; Dr. N. J. Wegmann, 2510 West Capitol Drive, Milwaukee, 1957; Dr. J. P. Conway, 1800 East Capitol Drive, Milwaukee, 1958.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. W. P. Curran, Antigo, 1956.

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* Map indicating location of councilor districts, page 85.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

Standing Committees—1955-1956

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A. R. Curreri, M.D., 1958, 1300 University Avenue, Madison

W. S. Bump, M.D., 1956, 1020 Kabel Avenue, Rhinelander

J. W. Conklin, M.D., 1956, Platteville

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P. B. Blanchard, M.D., 1957, Cedarburg

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R. B. Larsen, M.D., 1958, 510 Third Street, Wausau

G. I. Ulrich, M.D., 1956, 212 South Eleventh Street, La Crosse

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R. J. Schacht, M.D., 1956, 1704 Milwaukee Avenue, Racine

Committee on Grievances

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E. W. Mason, M.D., 1956, 324 East Wisconsin Avenue, Milwaukee 2

E. D. Sorenson, M.D., 1956, Elkhorn

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F. A. Nause, M.D., 1958, 927–A North Eighth Street, Sheboygan

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I. E. Schiek, Jr., M.D., 1959, 114 West Davenport Street, Rhinelander.

J. W. Boren, Jr., M.D., 1960, 1510 Main Street, Marinette

A. P. Zlatnik, M.D., 1957, 1421 Seventeenth Street, Two Rivers

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Committee on Coordination of Medical Services

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J. F. Maser, M.D., 1956, Rice Lake

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D. M. Willison, M.D., 1958, 314 East Grand Avenue, Eau Claire

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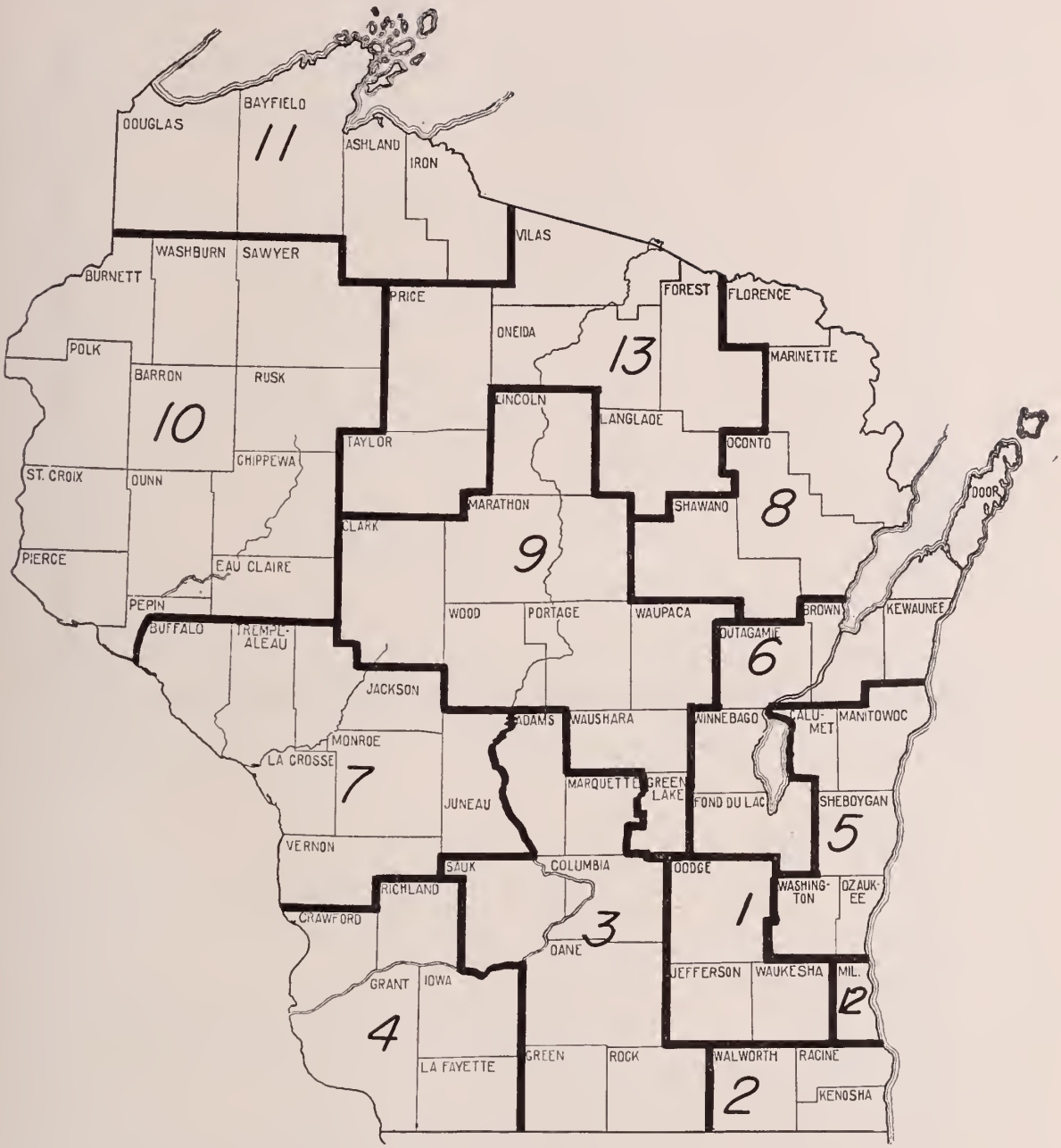

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Eleventh District:
Dr. V. E. Ekblad, Superior
Twelfth District:
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Dockendorff, B. C.
Weber, F. T.

Argyle
Hunter, R. E.

Arpin:
Ryan, C. J.

Ashland:
Bargholtz, W. E.
Butler, Albert
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Larson, H. H.
Jauquet, J. M.
Krener, J. E.
Merrill, W. G.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, C. J.
Smiles, W. J.
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.
Bachhuber, H. M.

Avoca:
Reynolds, Bertha

Augusta:
Moland, O. G.
Thieda, E. S.

Bailey's Harbor:
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Pischke, E. F.
Stoops, W. A.

Barron:
Guy, J. R.
Hammond, D. F.
Strang, C. J.
Templeton, H. M.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Corso, Xavier
Costello, W. H.
Davis, T. C.
Drescher, G. G
Hoyer, A. A.
Hoyer, E. C.
Kores, A. B.
Qualls, C. L.
Roberts, R. R.
Szweda, J. A.
Urbanek, R. E.
Vrabec, A. P.
Webb, E. P.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Belmont:
Turgeson, J. F.

Beloit:
Allen, W. J.
Baldwin, R. M.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Cauldwell, E. W.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Crone, V. D.
Fitzgerald, W. M.
Flarity, T. H.
Fosse, Benjamin
Freeman, W. S.
Glesne, O. G.
Gunderson, R. H.
John, G. W.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Raube, H. A.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

Berlin:
Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black River Falls:
Krohn, Robert
Kuglitsch, E. F.
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Brooks, E. H.
Edwards, P. K.

Bonduel:
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

Brandon:
Lautenbach, E. T.

Brillion:
Guthrie, J. M.
Langmack, W. A.

Brodhead:
Stovall, W. D., Jr.
Stuessy, M. W.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Carroll, J. H.
Erickson, L. W.
Granzeau, H. W.
Kempton, L. V.
Mastalir, L. O.
Newell, F. F.
Sroka, Wm. C.
Van Liere, J. D.

Butler:
Schoeneman, R. H.

Cadott:
Haines, B. J.
Zenner, C. E.

Cambria:
Brown, J. G.

Cambridge:
Amundson, K. K.
Rilstad, G. E.
Nora, J. J.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.

Chilton:
Goggins, J. W.
Humke, E. W

* As of December 15, 1955

Humke, K. R.
Knauf, N. J.

Chippewa Falls:
Brown, F. J.
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Janc, W. F.
Kelly, J. A.
Kemper, C. A.
McHugh, F. T.
Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Smith, Thorsten

Clear Lake:
Campbell, L. A., Jr.

Cleveland:
Feider, A. P.

Clinton:
Biason, P. M.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Caskey, H. S.
German, J. D.
Larson, Owen E.
Miller, E. A.
Mulvaney, J. J.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Hansen, R. L.
Koch, James W.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Poser, E. M.
Poser, J. F.
Poser, R. F.
Shearer, C. F.

Cornell:
Hendrickson, R. L.
Rahn, B. F.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Rosmann, H. K.
Taylor, H. W., Jr.
Terry, R. E.

Cudahy:
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Frederick, J. J.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Malone, J. A.
Pizer, J. A.

Cumberland:
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Dallas:
Erdlitz, F. J.

Darien:
Truex, G. O.

Darlington:
McConnell, E. D.
McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Levin, H. M.
Martin, J. E., Jr.
Moses, R. A.
O'Keefe, F. L.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Bergwall, W. L.
Hering, G. V.
Michna, C. T.

De Pere:
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Hamilton, W. P.
Morton, H. H.
Walker, H. M.

Dousman:
Notbohm, W. R.
Watry, T. D.

Durand:
Blose, Irvin L.
Bryant, R. J.

Eagle
Rosenkranz, W. F.

Eagle River:
Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.
Pace, A. J.

East Ellsworth:
Klaas, F. B.

East Troy:
Budnick, T. J.
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Bates, P. J.
Beebe, G. W.
Blom, Julius
Buckley, R. A.
Cameron, W. G.
Conlon, H. J.
Derge, H. F.
Falstad, C. H.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Hoff, D. E.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
McAffee, G. D.
Midelfart, Peter
Nester, H. D.
Nezworski, L. G.
Parrish, J. G., Jr.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Stewart, Katherine
Strand, R. C.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.
Vanstane, V. R.

Eleho:
Dailey, D. W.
Dailey, P. J.

Eleva:
Martins, J. K.

Elkhart Lake:
Martineau, J. E.

Elkhorn:
Bill, K. C.
Hatfield, Margaret E.
Helmbrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.
Young, J. H.

Ellsworth:
Aanes, A. R.

Elm Grove:
Blake, W. J.
Grade, J. O.
Redlin, R. R.
Schmidt, E. A.
Zurheide, H. J.
Zurheide, H. J. O.

Elmwood:
Springer, F. A.
Springer, J. P.

Elroy:
Curtis, W. E.
Demke, R. L.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Arnesen, P. M.
Becker, N. O.
Borsack, K. K.
Cerny, F. J.
Coyne, John F.
Devine, H. A.
Devine, J. C.
Flanagan, C. M.
Folsom, W. H.
Fransway, R. L.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Leonard, C. W.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Myers, W. E.
Pallin, Josephine J.
Pawsat, E. H.
Peterson, C. R.
Schroeder, R. W.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Willson, D. D.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Young, Will

Fox Lake:
Elliott, E. S.

Frederic:
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Gays Mills:
Boyce, S. R.
Schott, O. J.

Genoa City:
McNeel, Laird

Gillett:
Bailey, D. M.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Gilldden:
Ansfield, F. J.

Gordon:
Lorenz, Wm. F.

Grafton:
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Hartzell, R. L.

Green Bay:
Atkinson, H. S.
Austin, S. D.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Charbonneau, A. A.
Clark, E. V., Jr.
Cowles, R. L.
Daley, E. F.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Edelblute, L. H.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, F. J.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hipps, C. J.
Hitch, O. M.
Icks, K. R.
Iwen, G. W.
Jensen, R. E.
Kane, Elizabeth D.
Kaufman, J. E.
Killeen, E. R
Killins, J. A.
Killins, W. A.
Kispert, R. W
Klobucar, J. L. J.
Kuehl, F. O.
Kuhs, M. L
Kulkoski, Bernard
Lepper, W. E.
LeTellier, M. S.
Levitas, I. E.
McCarey, Arthur J.
McDermott, J. F.
McGuire, G. E.
Mickle, K. C.
Miller, L. C.
Milson, Louis
Mokrohisky, S. M.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V. F.
Paine, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
Schmidt, R. T.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Sullivan, Donel
Troup, R. L.
Troup, W. J.
Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Curtin, J. J.

Green Lake:
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Beil, E. J.
Pierce, D. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Hoffmann, J. G
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. O.
Quandt, V. V.
Sachse, F. W.

Hurtland:
Hansen, R. T.
Howlett, J. R.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Sandell, S. T.

Hayward:
Callaghan, D. H.
Krueger, E. R.
Sahs, M. H.
Wyant, M. E.

Hazel Green:
Althaus, C. F.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Boston, T. E.
Leuther, P. A.
Sanford, L. L

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.

Hortonville:
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Livingstone, J. W.
Newton, J. E.

Hurley:
Bonacci, M. J.
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Peterson, D. R.

Iola:
Wiley, R. H.

Jackson:
Albrecht, J. E.
Evans, H. C.

Janesville:
Bartels, G. W.
Baumgartner, M. M
Betlach, Dorothy W.
Betlach, Eugene H.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, Gerald P.
Gutmann, G. E.
Hartlaub, E. S.
Johnson, W. L.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Nuzum, T. O.
Odland, P. K.
Otterholt, E. R.
Overton, O. V.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroeder, Jack D.
Schroder, John R.
Sholl, R. P.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Tordoff, J. J.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Caswell, H. O.
Garding, C. J.
Quandt, C. E.
Quandt, R. W.
Robinson, A. H.

Johnson Creek:
Wendt, F. A.

Junction City:
Reis, G. W.

Juneau:
Erickson, N. W.
Ferguson, E. C.
Heath, H. J.

Kaukauna
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Flanagan, G. J.
Riordan, J. F.
Russo, J. G.

Kendall:
Curtis, W. E.

Kenosha:
Altman, J. S.
Ambro, P. J.
Andre, E. F.
Ashley, R. W.
Bertolaet, E. E.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Creighton, L. H.
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hill, B. Spaulding
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Meaney, J. J.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Pirsch, Margaret V.
Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauch, A. M.
Rauen, L. M.
Richards, C. G
Richards, J. N.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Turner, Lewis III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Williams, F. C., Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Lanier, A. S.
Lanier, Patricia A.
Nesemann, R. M.
Witcpalek, E. W.

Kiel:
Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:
Curtin, D. W.
Gage, Ralph S.

King:
Hathaway, G. J.
Montgomery, R. C.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

La Crosse:
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Britt, A. G.
Bruder, V. F. J.
Buchman, D. M.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
Egan, J. F.
Ernst, F. W.
Fox, J. C.
Flynn, R. E.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C
Getz, Kaare
Gilbert, R. L.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B
Gundersen, S. B., Jr.
Gundersen, T. E.
Harman, J. C.
Heraty, J. E.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jones, W. J.
Kirn, G. J.
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Ramlow, R. W.
Rasmus, R. B.

Reay, G. R.
Richter, J. R.
Ridout, G. B.
Satory, J. J.
Scheurich, Mary B.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Slvertson, Martin
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Smith, D. S.
Swarthout, Edyth C.
Uhrich, G. I.
Watunya, M. J.
Wolf, F. H.

Ladysmith:
Bauer, W. B. A. J
Bennett, R. P.
Lundmark, L. M.
Murphy, J. E.
Pagel, H. F.

La Farge:
Gollin, F. F.

Lake Geneva:
Brady, C. J.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.

Lake Mills:
Eck, G. E.
Liebenow, R. R.
Netzow, E J.
Peterson, M. G.
Schoenecker, E. A

Lancaster:
Bauman, K. L
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Suits, J. J.
Taylor, R. D.
Vedder, C. A.
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Wink, R. H.

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Vedner, J. H.

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Schultz, Isadore

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Hildebrand, G. B.
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Jensen, F. G.
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Nebel, J. R.
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Schwei, G. P.

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Drescher, A. A.
Gardner, Robert J.
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Bauch, N. G.
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Jacobson, E. B.
Jacobson, F. J.
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Jefferson, R. A.
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Jenner, J. A.
Jennings, T. F.
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Johnson, A. W.
Johnson, Frances
Johnson, H. W.
Johnson, J. A.
Johnson, J. H.
Johnston, T. L.
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Junck, J. A.
Junkerman, C. L.
Jurgens, G. H.
Jurishica, A. J.
Jurss, Charles D.
Kagen, Louis
Kah, W. W.
Kalb, C. H.
Kane, A. M.
Kanin, H. J.
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Kassowitz, K. E.
Kaufman, Bernhard
Kaufman, K. K.
Kaufman, L. W.
Kay, E. M.
Kearns, J. W.
Kearns, W. M.
Kebbekus, R. A.
Kelble, J. A.
Kelly, G. F.
Kettelhut, E. J.
Killan, A. D.
Kilkenny, G. S.
Kling, J. J.
King, J. M.
Kirmse, T. W.
Kissling, A. C., Jr.
Klein, J. T.
Klein, Morris
Kleis, W. J.
Klieger, J. A.
Kline, C. L.
Klopf, H. M.
Klumb, M. G.
Knudson, A. H.
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Kocovsky, E. C.
Kohler, S. H.
Kohn, A. M.
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Kretchmar, L. H.
Kretchmar, Morris
Kreuter, G. C.
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Krueger, F. J.
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Krumenacher, F. P.
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Ladewig, H. C.
Lang, V. F.
Langjahr, A. R.
Larkey, Jay A.
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Lee, H. J.
Lee, P. A.
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Levy, E. S.
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Light, George
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Lipscomb, T. C.
Lobedan, E. T.
Lochowitz, N. J.
Long, C. W.
Lungmus, B. A.
Lustok, M. J.
Madden, R. F.
Madison, F. W.
Madison, J. D.
Majewski, J. T.
Malloy, D. J.
Malloy, P. J.
Malloy, T. G.
Malnekoff, B. J.
Mann, R. W.
Marck, Abraham
Margoles, F. C.
Margoles, Milton
Marks, J. L.
Markson, J. W.
Markson, L. S.
Marlewski, C. R.
Marquardt, C. R.
Martens, E. W.
Martin, A. G.
Martineau, E. L.
Mason, E. W.
Maxwell, H. P.
Maxwell, J. W.
Maxwell, N. G.
Mayer, H. H.
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McCabe, John
McCabe, J. O.
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McCarty, R. T.
McCormack, M. T.
McCormick, R. A.
McCormick, T. F.
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McDonald, R. E.
McElligott, J. A.
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McNamara, L. V.
McNary, J. F.
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Mendeloff, Hyman
Mensing, E. H.
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Meyer, J. M.
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Millen, F. J.
Miller, E. W.
Miller, H. L.
Millington, P. E.
Miner, D. L.
Miner, H. B.
Mitz, Morris
Moel, Morris
Molsberry, J. M.
Monroe, M. W.
Montgomery, R. P.
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Moore, G. E.
Morgan, J. E.
Morgan, S. F.
Morter, H. V.
Morter, R. E.
Morton, S. A.
Mountain, D. C.
Muehlhaus, F. R.
Mueller, G. F.
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Murphy, J. A.
Murphy, T. R.
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Niland, P. T.
Nimz, F. N.
Nimz, R. A.
Northey, T. M.
Norton, R. C.
Oberbreckling, P. E.
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Ottenstein, H. H.
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Owen, J. D.
Owens, A. J.
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Peters, L. M.
Peterson, E. F.
Peterson, J. C.
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Pfeffer, T. J.
Pfeifer, W. M.
Phillips, W. S.
Pick, J. W.
Pierson, P. S.
Plnk, J. J.
Pinney, J. C.
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Popp, Albert
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Prudowsky, H. H.
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Purtell, R. F.
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Ravitz, L. A.
Raymond, A. J.
Regan, J. M.
Regan, J R.
Relfenrath, I. B.
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Reinke, C. C.
Rettig, E. H.
Rettig, Frank
Reuter, M. J.
Rhelneck, A. F.
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Rice, E. M.
Rice, R. L.
Rife, C. S.
Rikkers, D. F.
Ritchle, Gorton
Ritter, J. W.
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Robbins, L. S.
Roberts, D. W.
Roberts, H. M.
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Rogers, M. F.
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Schelble, J. A.
Schelble, J. P.
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Schlomovitz, H. H.
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Schmidt, C. E.
Schmidt, D. K.
Schmidt, E. C.
Schmidt, E. J.
Schmidt, H. G.
Schmidt, R. E.
Schmit, Louis
Schmitz, J. T.
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Schneeberger, L. J.
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Schneider, C. R.
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Schutte, A. G.
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Schwade, L. J.
Schwartz, A. B.
Schwartz, S. F.
Schweiger, L. R.
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Schweitzer, W A.
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Seelman, J. J.
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Sennett, L. W.
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Shaner, G. O.
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Shutkin, M. W.
Shutter, H W.
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Silbar, S. J.
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Sinsky, J. E.
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Stefanez, J S.
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Stemper, J. A.
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Strand, C. M.
Straus, G. D.
Studley, W. H.
Stuhler, J. D.
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Tolan, T. L.
Torcivia, S. S.
Trangsrud, H. A.
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Tufts, Millard
Turney, C. F.
Twelmeyer, H. F.
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Usow, E. J.
Uszler, L. B.
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Verch, L. H.
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Wagner, Marvin
Wagner, P. C.
Waisbren, B. A.
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Walker, L. J.
Walton, W. B.
Warner, R. C.
Warschauer, Bruno
Warth, C. G.
Washburn, R. G.
Watson, H. J., Jr.
Watson, R. R.
Watts, Alice D.
Waxman, S. I.
Webb, W. C.
Weber, A. J.
Weber, J. E.
Weber, M. L.
Weed, L. G.
Wegmann, G. H.
Wegmann, N. J.
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Weingart, W. F.
Weinshel, L. R.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wendt, W. P.
Wepfer, J. F.
Werba, D. R.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Whitaker, P. J.
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Wilets, J. B.
Wilets, J. C.
Williams, Delore
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
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Wolter, S. H.
Wolters, H. F.
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Cales, J. O.
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Kindschl, L. G.
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Miller, C. O.
Mings, D. E
Moore, L. A.
Olson, M. J.
Ruehlman, D. D.
Schindler, J. A.
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Stlles, F. C.
Weir, J. R.
Witte, K. B.
Zach, R G.

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Inman, R. F.

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Rasmussen, N. G.

Monticello:
Lucas, P. M.
Miller, C. O.

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Baird, H. D.
Pierpont, J. M.

Mosinee:
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Mount Calvary:
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Miller, J. F.

Mount Horeb:
Buckner, H. M.
Morrison, M. T.

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Voellings, W. J.

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Ackerman, E. T.
Klockow, W. E.

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Kelm, G. J.

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Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
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Neopit:
Knauf, J. W.

New Auburn:
Stang, H. M.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J.
Hicks, E. V.
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Weston, C. L.

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfelfer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
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Epley, O. H.
Healy, J. P.

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Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
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Siefert, C. E.

Ogema:
Rinehart, B. M.

Omro:
Peck, D. D.
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Johnson, E. S.
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McNair, E. R.

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Danforth, Q. H.
Emrich, P. S.
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Kuhn, R. V.
Leibenson, S. J.
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Murphy, J. L.

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Barrette, Antoine
Haasl, H. W.

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Cunningham, Wilson
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Moffett, J. L.

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McNichols, E. R. ---------- Memphis, Tennessee
Megna, Salvatore ---------- Tucson, Arizona
Mendez, R. G. ---------- Garden Grove, California
Merdinger, W. F., Jr. ---------- Duarte, California
Middleton, W. S. ---------- Washington, D. C.
Nicolai, C. H. ---------- St. Louis, Missouri
O'Donnell, Mae J. ---------- Wadsworth, Kansas
Olson, D. E. ---------- Portland, Oregon
Olson, R. C. ---------- Menominee, Michigan
Peterson, Freddie N. ---------- Lake Forest, Illinois
Peterson, G. J. ---------- Pontiac, Michigan
Pfeifer, R. H. ---------- Ft. Lauderdale, Florida
Puckett, R. W. ---------- Arcadia, California
Radke, L. M. ---------- San Diego, California
Reay, G. D. ---------- Douglas, Arizona
Reibold, F. W. ---------- Grand Rapids, Michigan
Sadler, P. E. ---------- Phoenix, Arizona
Schaefer, Margaret A. ---------- Aurora, Illinois
Schoen, R. F. ---------- Casa Grande, Arizona
Settimi, A. L. ---------- Indio, California
Sherman, C. F. ---------- Temple, Texas
Steele, J. D., Jr. ---------- San Fernando, California
Stehlin, J. S., Jr. ---------- Houston, Texas
Thimke, H. E. ---------- Iowa City, Iowa
Truitt, J. W. ---------- Tulsa, Oklahoma
Van Kirk, F. W. ---------- San Francisco, California
Van Riper, H. E. ---------- New York, New York
Verbrick, W. C. ---------- Minneapolis, Minnesota
Waters, R. M. ---------- Orlando, Florida
Wells, May R. ---------- Belleville, Illinois
White, E. F. ---------- Harlingen, Texas
Youngstrom, C. S. ---------- Detroit, Michigan

Honorary Members of County and State Societies

Bradley, H. C. ---------- Oakland, Calif.
Clark, P. F. ---------- Madison
McCracken, R. W. ---------- Union Grove
Meek, W. J. ---------- Madison
Pusey, W. A. ---------- Chicago, Illinois
Sisk, I. R. ---------- Madison
Sullivan, W. E. ---------- Denver, Colo.
Taylor, J. Gurney ---------- Miami, Fla.

Life Members of State Medical Society

Allen, W. J. ---------- Beloit

Baker, G. R. ---------- Tomahawk
Bayer, W. H. ---------- Merrill
Bear, W. G. ---------- St. Petersburg, Fla.
Beebe, S. D. ---------- Sparta
Bolton, E. L. ---------- Appleton
Boyce, S. R. ---------- Gays Mills
Brehm, H. J. ---------- Racine
Brooks, E. H. ---------- Bloomington
Brunckhorst, F. O. ---------- Neenah

Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Caswell, H. O. ---------- Jefferson
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Cunningham, Wilson ---------- Platteville

Donohue, M. J. ---------- Antigo

Fazen, L. E. ---------- Racine
*Fellman, G. H. ---------- Milwaukee
Folsom, W. H. ---------- Fond du Lac
Forkin, G. E. ---------- Menasha
Friend, L. J. ---------- Milwaukee
*Fuller, M. H. ---------- Green Bay

Gavin, S. E. ---------- Fond du Lac
Giesen, C. W. ---------- Superior
Grosskopf, E. C. ---------- Waukesha

Hammond, F. W. ---------- Manitowoc
Haubrick, H. J. ---------- Oshkosh
Heraty, J. E. ---------- La Crosse

Junck, J. A. ---------- Milwaukee

Kleinboehl, J. W. ---------- Mercer

Leonard, C. W. ---------- Fond du Lac
Linn, W. N. ---------- Oshkosh
Lockhart, C. W. ---------- Mellen
Lockhart, J. W. ---------- Oshkosh
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Lundmark, L. M. ---------- Ladysmith

Madison, J. D. ---------- Milwaukee
Marshall, V. F. ---------- Appleton
*Mason, E. L. ---------- Eau Claire
*Meusel, H. H. ---------- Oshkosh

Nadeau, A. T. ---------- Marinette
Notbohm, W. R. ---------- Dousman

Peehn, F. G. ---------- Sturtevant
Pomainville, F. X. ---------- Wisconsin Rapids
Pope, F. W. ---------- Racine
Potter, R. P. ---------- Marshfield

Quick, E. W. ---------- Milwaukee

Radloff, A. C. ---------- Plymouth
Raymond, R. G. ---------- Brownsville

Schmidt, E. S. ---------- Green Bay
Schmit, Louis ---------- Milwaukee
Schroeder, H. F. ---------- Marinette
Smith, S. M. B. ---------- Wausau
*Stebbins, W. W. ---------- Madison

Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Twohig, D. J. ---------- Fond du Lac

*Washburn, R. G. ---------- Milwaukee
Webb, E. P. ---------- Beaver Dam
Wheeler, W. P. ---------- Oshkosh

* Granted life membership in 1955.

SECTIONAL MEETING OF AMERICAN COLLEGE OF SURGEONS MILWAUKEE, FEBRUARY 27–29, 1956

All physicians are invited to attend the three-day sectional meeting of the American College of Surgeons to be held at the Hotel Schroeder, Milwaukee, from February 27 through February 29.

Among the topics to be considered are handling of mass casualties, fractures in children, hypothermia in cardiac and general surgery, carcinoma of the prostate, tumors of the thyroid, cancer of the colon, intestinal obstruction, problems in operability, operative versus medical treatment of diseases of the thyroid gland, endocrinology in gynecology, congenital defects of the head and neck, biliary tract surgery, and diverticulitis of the colon.

Special hospital clinics will be offered on Tuesday morning, February 28, at Milwaukee County Hospital and on Wednesday morning, February 29, at the Veterans Hospital.

Medical motion pictures and cine clinic films will also be included in the program.

Special luncheon meetings are planned for gynecologists and obstetricians and for ophthalmologists and otolaryngologists.

At a Tuesday evening dinner meeting, Dr. Paul C. Hawley, The Director, ACS, will give a brief report on the work of the College. Two films—"Big Game Hunt in British Columbia," personally made by Dr. R. V. Landis, Appleton, and "Danger at the Source," concerned with the problem of more support for the nation's medical schools—will be shown.

Wisconsin surgeons, including faculty members from Marquette University and the University of Wisconsin, will be assisted by such visiting talent as Brock E. Brush, Dwight E. Clark, Warren H. Cole, George Crile, Jr., Edwin H. Ellison, John B. Erich, Joseph P. Evans, Donald J. Ferguson, George H. Gardner, R. Kennedy Gilchrist, Frank Glenn, Samuel P. Harbison, James B. Hartgering, Charles C. Higgins, C. Paul Hodgkinson, N. Logan Leven, F. John Lewis, Charles W. McLaughlin, Jr., Samuel Meyer, H. Mason Morfit, Rudolf J. Noer, Bradley M. Patten, Ralph A. Reis, Harold G. Scheie, Joseph R. Shaeffer, Derrick Vail, John M. Waugh and Robert Bruce Wilson. Dr. Forrester Raine, Milwaukee, is chairman of the advisory committee on arrangements.

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STARTING DATES—WINTER–SPRING, 1956

SURGERY—Surgical Technic, Two Weeks, February 6, February 20
Surgical Anatomy & Clinical Surgery, Two Weeks, March 5
Surgery of Colon & Rectum, One Week, February 27, April 9
General Surgery, One Week, February 13; Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Gallbladder Surgery, Ten Hours, April 9
Fractures & Traumatic Surgery, Two Weeks, March 12
GYNECOLOGY—Office & Operative Gynecology, Two Weeks, February 13, March 12
Vaginal Approach to Pelvic Surgery, One Week, February 6, March 5
OBSTETRICS—General & Surgical Obstetrics, Two Weeks, February 27, March 26
MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two-Week Basic Course, March 12
Gastroscopy, Forty-Hour Course, March 19
Dermatology, Two Weeks, May 7
RADIOLOGY—Diagnostic X-Ray, Two Weeks, February 6, April 30
Clinical Use of Radioactive Iodine, One Week, April 2
Clinical Uses of Radioisotopes, Two Weeks, May 7
PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases: Cerebral Palsy, Two Weeks, June 18
UROLOGY—Two-Week Course, April 16
Cystoscopy, Ten Days, by appointment

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Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As amended by the 1955 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include. and. when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Medical Education and Hospitals.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Hospital Relations.
A Committee on Cancer.

Unless otherwise provided in these By-laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of five members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen be-

tween a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The term of office shall be pursuant to the constitution and by-laws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and by-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and dis-

plays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

THESE GUIDES MAY HELP YOU

The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.

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SAMPLES and LITERATURE ON REQUEST

1. Plotz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)
4. Russek and Assoc., Am. Jl. Med. Sciences (Jan. 1955)
5. Biegeleisen, Clinical Medicine (Oct. 1955)

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Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician. The ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times; as a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule, and who conducts his affairs in the light of his own conscientious interpretation of these principles will find no difficulty in the discharge of his professional obligations.

CHAPTER 1

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He shall also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—The avowed objective of the profession of medicine is the common good of mankind. Physicians faithful to the ancient tenets of this profession are ever cognizant of the fact that they are trustees of medical knowledge and skill and that they must dispense the benefits of their special attainments in medicine to all who need them. Physicians dedicate their lives to the alleviation of suffering, to the enhancement and prolongation of life, and to the destinies of humanity. They share whatever they have learned and whatever they may discover with their colleagues in every part of the globe. They recognize instinctively that the need of improvement of medical knowledge and skills is never at an end, and while they strive toward satisfaction of this need they are zealous in making available to physicians of good character who possess the desire and the ability to learn the aggregate of progress in medical education, research, and discoveries as they may exist at the time. They do not remain content to limit their activities to the care of the infirm, since they recognize also their useful rank among the vast concourse of citizens on whose shoulders the destiny of our nation rests. At the same time they will resist attempts to debase their services by diverting them to ignoble purposes. In their relationship with patients, with colleagues, and with the public, they maintain under God, as they have down the ages, the most inflexible standards of personal honor.

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some

localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PAYMENT FOR PROFESSIONAL SERVICE

SEC. 6.—The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.

Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of the division of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.

When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, "kickbacks," discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.

Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor–patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care.

PATENTS AND COPYRIGHTS

SEC. 7.—A physician may patent surgical instruments, appliances and medicines or copyright publications, medicines and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical.

SEC. 8.—It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient.

REBATES AND COMMISSIONS

SEC. 9.—The acceptance of rebates on prescriptions and appliances or of commissions from those who aid in the care of patients is unethical.

SECRET REMEDIES

SEC. 10.—The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 11.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, AND NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

---

* Nicon, father of Galen.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

Article I.—Duties to the Profession

UPHOLDING THE HONOR OF THE PROFESSION

Sec. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

Sec. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

Sec. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

Sec. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

Article II.—Professional Services of Physicians to Each Other

DEPENDENCE OF PHYSICIANS ON EACH OTHER

Sec. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

Article III.—Duties of Physicians in Consultations

CONSULTATIONS SHOULD BE ENCOURAGED

Sec. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATIONS

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

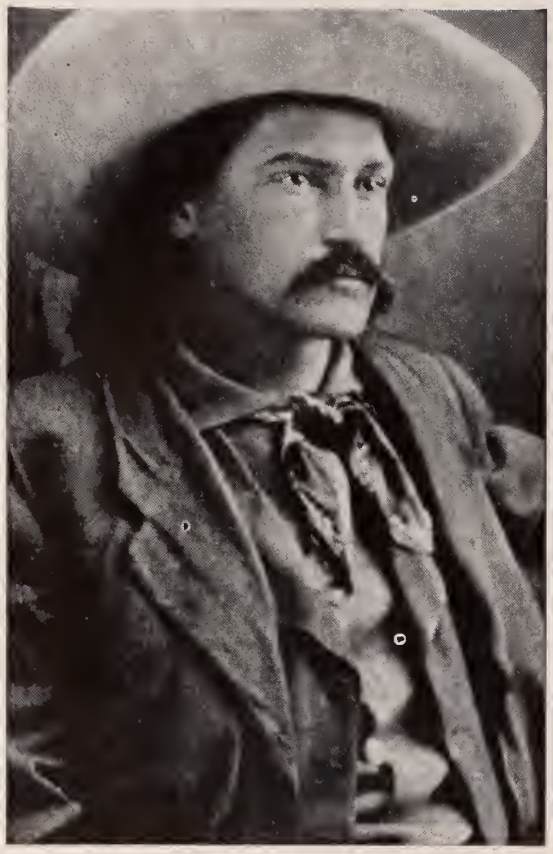
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY MEETING

The nineteenth annual meeting of the New Orleans Graduate Medical Assembly will be held February 27, 28, 29 and March 1, with headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, color television, medical motion pictures, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1956 meeting in New Orleans. On Friday, March 2, a party composed of doctors and their families will leave New Orleans for the West Indies and Central America via plane. The itinerary includes Puerto Rico, St. Thomas, Haiti, Jamaica, Panama, and Guatemala; and arrangements have been made for medical programs in the places visited.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.



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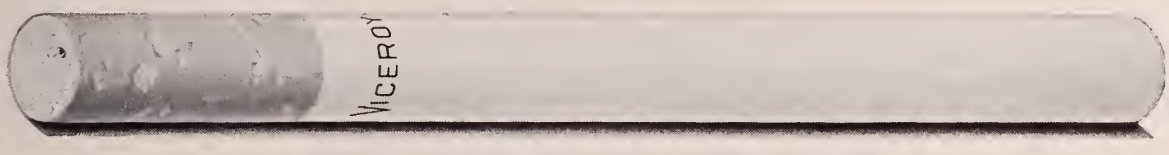

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Harmon Van Dusen, Mineral Point_1852, 1853, 1854
A. L. Castleman, Delafield_____1855
John Mitchell, Janesville_____1856
D. Cooper Ayres, Green Bay_____1857
Clark G. Pease, Janesville_____1858, 1859
E. S. Carr, Madison_____1860, 1861
Solomon Blood, Rochester_____1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, Mineral Point_1867, 1868, 1869
Solon Marks, Milwaukee_____1870
H. P. Strong, Beloit_____1871
John Favil, Madison _____1872
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* Died during term of office as president-elect.

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J. C. Griffith, Milwaukee----1953
H. Kent Tenney, Madison----1954
Arthur J. McCarey, Green Bay***----1955
Ervin L. Bernhart, Milwaukee----1955

** Resigned, because of health, prior to taking office.

*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.

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Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

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** Then president of the University of Wisconsin and professor of zoology.

*** Centennial Award.

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WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

A Formula Is Clarified

Periodically there has been question as to the interpretation of one or more of the Blue Shield multiple procedure formulas which are printed on the back of the Abbreviated Schedule of Benefits and on page 34 of the Wisconsin Physicians Service Manual.

One of these formulas was considered at a meeting of the Commission on Prepaid Plans on December 10–11, 1955. The question was the interpretation of Formula No. 5:

> "Where more than one procedure is performed during different periods of anesthesia and while related to the same sickness or accident, and there has been complete recovery from the earlier procedure, pay benefits assigned each procedure."

This formula can best be presented by an illustration:

Patient A is hospitalized because of diabetes, and its complications necessitate an operation. He subsequently recovers and returns to his occupation.

Three months later diabetic complications necessitate a further operation. The word "recovery" in the formula should be interpreted as though synonymous with "disability," and without regard to the prior operation the second operation should be treated as an entirely independent claim.

In other words, the physician who treated Patient A would be paid the benefits assigned to each of the surgical procedures involved in the two hospitalizations. The maximum of $700 which is applied to some of the formula items is not applied to this case.

The above interpretation of Formula No. 5 was approved by the Commission.

Considered at the same time because of its relation to the first problem was the interpretation of the situation presented by Formula No. 4 which reads:

> "Where more than one procedure is performed during different periods of anesthesia, but these are related to same sickness or accident, and during same period of hospitalization or disability."

In the case of Formula No. 4, benefits are paid for each procedure within a total limitation of $700.

Speakers for County Meetings

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Urology, Volume One. Edited by Meredith Campbell, M. S., M. D., F.A.C.S. Philadelphia and London, W. B. Saunders Company, 1954.

This very complete review of urology is the most recent and most complete of its kind. Although the basic anatomy and physiology is well covered in this first volume, much that is new and usually not included is presented also. The section on pediatric urological anomalies is written by the outstanding authority in the field, as are the sections on infertility and urolithiasis. This urological text is a welcome addition to any urological library—J. B. W.

Urology, Volume Two. Edited by Meredith Campbell, M. S., M. D., F.A.C.S. Philadelphia and London, W. B. Saunders Company, 1954.

The sections in this volume on pediatric and female urology give concise and complete coverages. They are written interestingly as well as being extremely informative. The section on urological tumors is the weakest section in the entire three volumes as it is out of date and unnecessarily complicated. Within these chapters all the various forms of pathology are presented, but leave a little to be desired as to simplicity. Otherwise this, as well as the other two volumes, is a complete and very necessary text for every medical school library.—J. B. W.

Urology, Volume Three. Edited by Meredith Campbell, M. S., M. D., F.A.C.S. Philadelphia and London, W. B. Saunders Company, 1954.

This is a very excellent text. It is complete enough for the urology resident and could serve as an excellent reference work for others, specialists and nonspecialists alike. It should be a part of every complete library.

The section on endocrinology and the adrenals is complete. The portion on urological surgery is very good and up to date.—J. B. W.

Peripheral Vascular Diseases. By Edgar V. Allen, B. S., M. A., M. D., M. S. in Medicine, F.A.C.P., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota, Diplomate of the American Board of Internal Medicine; Nelson W. Barker, B. A., M. D., M. S. in Medicine, F.A.C.P., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota, Diplomate of the American Board of Internal Medicine; and Edgar A. Hines, Jr., B. S., M. A., M. D., M. S. in Medicine, F.A.C.P., Professor of Medicine, Mayo Foundation, Graduate School, University of Minnesota. Second Edition. Philadelphia and London, W. B. Saunders Company, 1955.

This book is firmly based on the authors' vast clinical experience. It is divided into two sections: the first is a rather complete general discussion of peripheral vascular disease and the second a description of specific procedures to be followed for treatment of vascular disease. It is very well written with excellent illustrations. Topics are outlined for both ready orientation and review, and the references are adequate for those who prefer to seek the original work. Terminology, difficult in this field, is well presented.

It can be recommended both to students and practitioners as an excellent book.—G. G. R.

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Handbook of Medical Treatment. Edited by Milton J. Chatton, A. B., M. D.; Sheldon Margen, M. A., M. D.; and Henry G. Brainerd, A. B., M. D. Los Altos, California, Lange Medical Publications, 1954.

There is an amazing compilation of data, information on drugs and dosages, and directions in this manual. It is recommended as a convenient source book for many members and names which so easily elude the grasp of memory but are so necessary in prescribing therapy. This book is not likely to be a help in developing the physician's judgment in the finer points of therapy, but perhaps it was not intended to do so.

The book is remarkably up to date in regard to new drugs.

For one who desires a convenient source of explicit direction in therapy, this manual is highly recommended.—R. F. S.

A Textbook of Physiology. Edited by John F. Fulton, M. D., Sterling Professor of the History of Medicine, Yale University School of Medicine, with the collaboration of Donald H. Barron, Ph. D.; William D. Blake, M. D.; John R. Brobeck, Ph. D., M. D.; George R. Cowgill, Ph. D.; Paul F. Fenton, Ph. D.; Thomas R. Forbes, Ph. D; Samuel Gelfan, Ph. D.; David I. Hitchcock, Ph. D.; Hebbel E. Hoff, D. Phil., M. D.; David P. C. Lloyd, D. Phil.; Theodore C. Ruch, Ph. D.; and Jane A. Russell, Ph. D. Seventeenth Edition. Philadelphia and London, W. B. Saunders Company, 1955.

This edition gives the impression that much new subject matter, published since the edition of 1950, has been incorporated; and the presentation of subject matter seems better adapted for study by medical students. It is a very scholarly, comprehensive, scientific discussion of physiology, very much at the level of a monograph. At the end of each chapter there is an extensive list of references. It contains a wealth of facts on physiology. The 600 figures make it a well-illustrated text.—R. C. H.

Review of Medical Microbiology. By Ernest Jawetz, Ph. D., M. D., Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine; Joseph L. Melnick, Ph. D., Professor of Epidemiology, Yale University School of Medicine; and Edward A. Adelberg, Ph. D., Assistant Professor of Bacteriology, University of California. Los Altos, California, Lange Medical Publications, 1954. Price $4.50.

In the opinion of this reviewer, the so-called "Review of Medical Microbiology" is in reality another textbook on microbiology, which has been squeezed into fewer pages and printed more cheaply. There is a semi-outline arrangement of the material, and all references have been omitted. The small type and crowding of material on the page results in a book of some 360 pages as opposed to the standard text of about 800. The presentation is clear, concise, and up to date; but it would seem that the title is misleading. A student would do about as well to use a standard text.—C. V. S.

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Endemic Goiter. By John B. Stanbury, M. D., Gordon L. Brownell, Ph. D., Douglas S. Riggs, M. D., Hector Perinetti, M. D., Juan Itoiz, Ph. D., and Enrique B. Del Castillo, M. D. Cambridge, Mass., Harvard University Press, 1954. Price $4.00.

This is a report of the Andean Goiter Expedition of 1951, which made studies on iodine deficiency goiter occurring in Argentina. The first section describes the clinical observations made on 129 patients; the remaining two deal with the dynamic aspects of iodine metabolism as disclosed by isotopic studies. This account will be of interest primarily to endocrinologists.—E. C. A.

Man in a Cold Environment; Physiological and Pathological Effects of Exposure to Low Temperatures. By Alan C. Burton, Ph. D., Professor of Biophysics, University of Western Ontario, and Otto G. Edholm, M. B., B. S., Head of Division of Human Physiology, National Institute for Medical Research, Medical Research Council, England. London, Edward Arnold (Publishers) Ltd., 1955. Price $6.75.

This book fills a need for an up-to-date listing and description of references to studies in hypothermia and cold physiology. It appears to be fairly complete in this respect. It is of additional value insofar as it covers the topics concerned in a logical and clear-cut manner. It will be an indispensable handbook for those interested in the physiological effects of cold both in man and experimental animals. Its coverage of pathology is somewhat less extensive than its physiological emphasis. It touches on the ecological aspect of cold physiology, and there is rather heavy emphasis on biophysical measurements.—A. R. D.

A Synopsis of Medicine. By Sir Henry Letheby Tidy, K. B. E., M. A., M. D., B. Ch. (Oxon), F.R.C.P. (Lond.); Extra Physician to H. M. the Queen; Consulting Physician to St. Thomas's Hospital; Hon. Major-General, lately Consulting Physician to the British Army. Tenth Edition. Baltimore, The Williams and Wilkins Company, 1954.

The fact that this is a tenth edition testifies to the fact that a considerable number of physicians must have found *A Synopsis of Medicine* by Sir Henry L. Tidy a useful volume. It is prepared in outline form and resembles to some extent a set of lecture notes. Coverage of internal medicine and allied fields such as neurology is extensive. The book would probably have its greatest function as a quick reference to be kept in a desk drawer or other easily accessible place so that the physician might look up a specific point which he should know but could not recall at the moment. It is hardly a book to be studied if exhaustive information about a specific disease process is desired. Because of its outline form, dogmatic statements on many subjects about which there are valid differences of opinion are presumably inescapable; and numerous examples of this can be found in the volume.—J. L. S.

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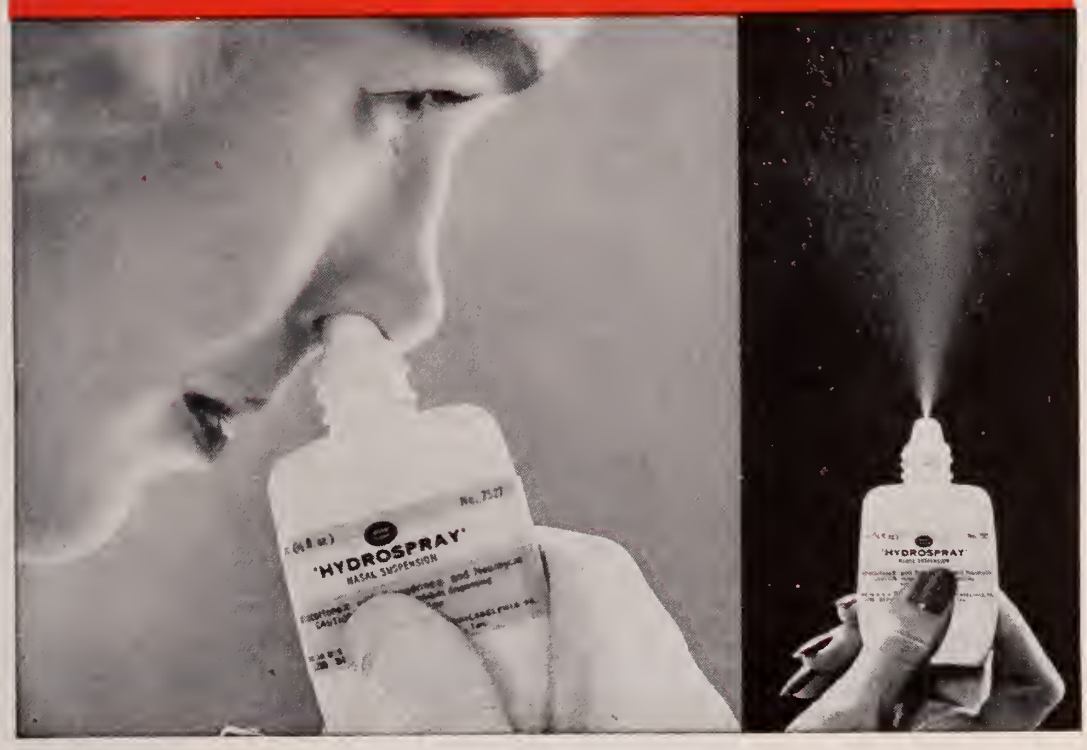

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Illustrated Review of Fracture Treatment. By Frederick Lee Liebolt, A. B., M. D., Sc. D., LL. D.; Attending Surgeon in Charge of Orthopedics, The New York Hospital; Attending Orthopedic Surgeon, Hospital for Special Surgery; Associate Professor of Clinical Surgery (Orthopedics), Cornell University Medical College. First Edition. Los Altos, California, Lange Medical Publications, 1954. Price $4.00.

This book deserves to be examined by all medical students and interns for it features what every medical student has wanted in a textbook at some time in his harassed periods: economy of cost, economy of size, economy of words, and an abundance of illustrations.

After the first three chapters encompassing anatomy and physiology, clinical features of fractures, and principles of treatment of fractures, the author discusses the skeleton by the usual regional units, and the various fractures in outline form: by etiology, incidence, pathology, clinical findings, complications, x-ray findings, and various accepted methods of treatment. Late complications, time of immobilization, and prognosis are also presented.

Line drawings illustrate the mechanism of fractures and types of displacement and clarify the text as to the methods of treatment. This book is not a surgical manual and procedures are not included.

This paper-bound manual would be very useful in connection with a textbook on fractures and dislocations and is recommended to medical students.—H. I. O.

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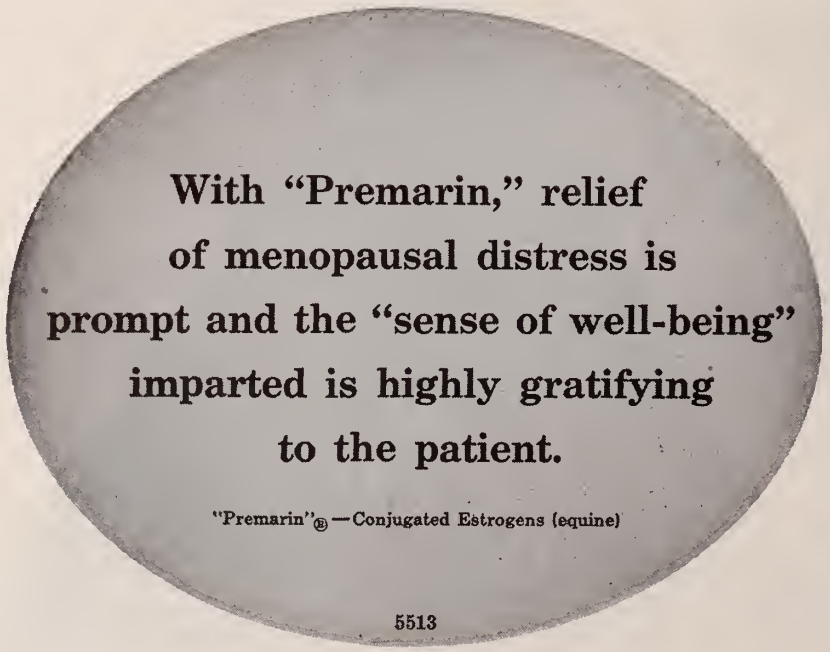
Ion Exchange and Adsorption Agents in Medicine; The Concept of Intestinal Bionomics. By Gustav J. Martin, Sc. D., Research Director, The National Drug Company, Philadelphia. Boston and Toronto, Little, Brown and Company, 1955. Price $7.50.

This book by a well-known biochemist describes the insult of intestinal absorption on the metabolism of the body. His thesis is that during intestinal absorption a whole host of toxic products are absorbed through the intestinal tract into the body and these become cumulative over a long period of time and certainly influence the health and disease of the individual. The medical history of any given individual is a reflection of the changes that occur in the body as a result of the biochemical reactions that result both from bacterial synthesis of toxic materials and the absorption of all food materials.

This author is very concerned about the "repeated insults from the tract that modify health and create pathology." He is aware of and recognizes the beneficial role of intestinal synthesis as far as vitamin and amino acid synthesis is concerned. The formation of toxic amines by intestinal bacteria has been a well-recognized physiological fact for some time, but this author questions whether their importance has been underrated.

This book is of great interest from the scientific as well as the provocative point of view and merits the attention of those individuals who are primarily concerned with geriatrics, since the author is aware of the fact that repeated insults begin to accumulate and may be the basis for many of the problems of old age.—H. A. W.



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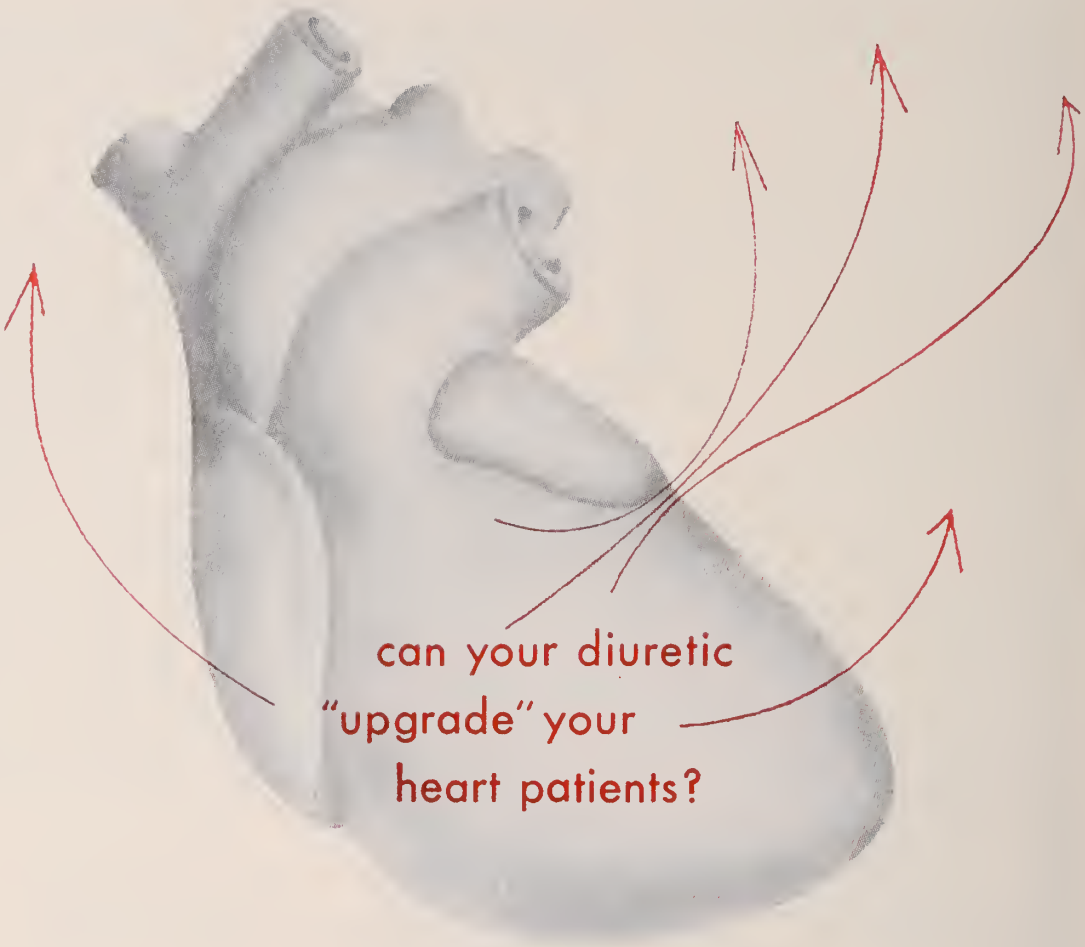

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American Meat Institute ____ 14
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Bayer Company ____ 7
Benson Optical Company ____ 86
Brown and Williamson Tobacco Corp. ____ 117
Burroughs Wellcome & Co., Inc. ____ 12

Canada Dry ____ 136
Chicago Medical Society ____ 109
Ciba Pharmaceutical Products ____ 120
Cook County Graduate School of Medicine ____ 99

Davies, Rose & Co. Ltd. ____ 121
Doerflinger Artificial Limb Co. ____ 130

Endocrine Laboratories ____ 99
Evron Company, Inc. ____ 110

Foot-so-Port Shoe Company ____ 5

Gyne–Cytology Laboratory ____ 125

Hotel Schroeder ____ 129
House of Bidwell ____ 121
Hurley X-Ray Company ____ 120

Keeley Institute ____ 124
Kennedy–Mansfield ____ 118
Knox Gelatine ____ 78

Lakeside Laboratories ____ 132
Lederle Laboratories ____ 74, 75
Lilly, Eli and Company ____ 18

Mallard, Incorporated ____ 128
Mallatt Pharmacy ____ 118
Marsh & McLennan ____ 122
Mather Pharmacy ____ 118
Mead Johnson and Company ____ 139
Medical Protective Company ____ 120
Milwaukee Sanitarium Foundation, Inc. ____ 140

New York Polyclinic ____ 125

Orthopedic Appliance Company ____ 5

Parke, Davis and Company ____ 2, 3
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc. ____ 6, 15, 135
Physicians Casualty Association ____ 134
Professional Business Service ____ 55

Quincy X-Ray and Radium Laboratories ____ 5

Rennebohm's ____ 118
Rogers Memorial Sanitarium ____ 140

S. and L. Signal Company, Inc. ____ 125
Sacred Heart Sanitarium ____ 119
St. Croixdale Sanitarium ____ 5
Schering Corporation ____ 11, 16, 17
Searle, G. D. and Company ____ 77
Smith, Kline & French Laboratories ____ 10
Sharp and Dohme ____ 127
Shorewood Hospital Sanitarium ____ 109
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp. ____ 81

Time Insurance Company ____ 53
Tutag, S. J., and Company ____ 4

Upjohn Company ____ 13, 129

Winthrop Laboratories ____ 131
Wisconsin Neurological Foundation ____ 99

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. E. Kreher Ashland	J. M. Jauquet 220 7th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe Rice Lake	F. H. Goetsch Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	Louis Milson 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	Kenneth Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	B. J. Haines Cadott	Second Tuesday
Clark	J. W. Koch Colby	T. N. Thompson Neillsville	
Columbia–Marquette–Adams	J. P. Harkins Portage	F. W. Gissal 132 Washington Ave. Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	W. S. Cusick Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. S. Gearhart 621 S. Park Madison	T. V. Geppert 113 N. Carroll Madison	Second Tuesday Sept. through June
Dodge	R. I. Bender 147 Front Beaver Dam	M. E. Royce Mayville	Last Thursday*
Douglas	Conrad Giesen 1514 Ogden Superior	J. McGinnis 2231 E. Fifth Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	R. A. Buckley 131 S. Barstow Eau Claire	G. E. Wahl 616 E. Grand Eau Claire	Last Monday
Fond du Lac	Josephine N. Pallin 73 W. 12th Fond du Lac	H. J. McLane 80 Sheboygan St. Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	W. J. Conklin Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	F. J. Bongiorno Albany	D. E. Mings Monroe Clinic Monroe	
Green Lake–Waushara	A. J. Wiesender Berlin	G. C. Stone 124 N. Wisconsin Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	R. W. Quandt 1108 Main Jefferson	C. E. Quandt 804 Lincoln Ave. Jefferson	Third Thursday*

* Except June, July, and August.

** Except July and August.

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	V. M. Griffin Hess Clinic Mauston	John E. Thompson Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. T. Garren 6124 Sheridan Rd. Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	A. A. Cook 1707 Main La Crosse	J. L. Jaeck 1836 S. Ave. La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	R. E. Hunter Argyle	Last Tuesday
Langlade	W. P. Curran Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah Merrill	
Manitowoc	R. C. Randolph 819 Hancock Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	E. B. Brick 501½ Third Wausau	J. V. Flannery 404 Third Wausau	
Marinette–Florence	P. R. McCanna 1510 Main Marinette	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	J. W. Fons Southgate 3333 South 27th Milwaukee	G. S. Kilkenny 945 N. 12th Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	A. F. Slaney Oconto	F. E. Zantow Oconto	
Onelda–Vilas	T. M. Haug 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	A. C. Taylor 103 W. College Appleton	H. T. Gross 103 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	F. B. Klaas East Ellsworth	P. H. Gutzler River Falls	Third Tuesday
Polk	F. L. Whitlark Amery	L. J. Weller Osceola	Third Thursday 7 p.m.
Portage	H. A. Anderson Stevens Point	W. A. Gramowski 319½ Main Stevens Point	
Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Lewis E. Fazen 725 Main Racine	F. M. Hilpert 312 Seventh Racine	Third Thursday
Richland	D. J. Taft Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	Francis Frechette 20 E. Milwaukee Janesville	H. M. Snodgrass 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	R. G. Knight Reedsburg	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	R. C. Cantwell Shawano	A. J. Sebesta Shawano	Third Tuesday
Sheboygan	R. H. Evers Rocky Knoll Sana- torium Route 3, Plymouth	R. M. Senty 1011 N. Eighth Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	C. B. Moen Galesville	E. P. Rohde Galesville	Fourth Tuesday
Vernon	L. F. Gulbrandsen Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	R. A. Moses Delavan	Glen Smiley Delavan	Second Thursday*
Washington–Ozaukee	M. E. Monroe 63 N. Main Hartford	J. F. Walsh 125 E. Main Port Washington	Fourth Thursday
Waukesha	Albert Rogers Waukesha	Phillip Wilkinson Waukesha	
Waupaca	K. L. Haman Waupaca	G. P. Dernbach New London	
Winnebago	J. E. Conway 144 Main Menasha	G. B. Hildebrand 216½ Main Menasha	First Thursday
Wood	G. L. McCormick 650 S. Central Ave. Marshfield	N. J. Helland 650 S. Central Ave. Marshfield	Four times a year

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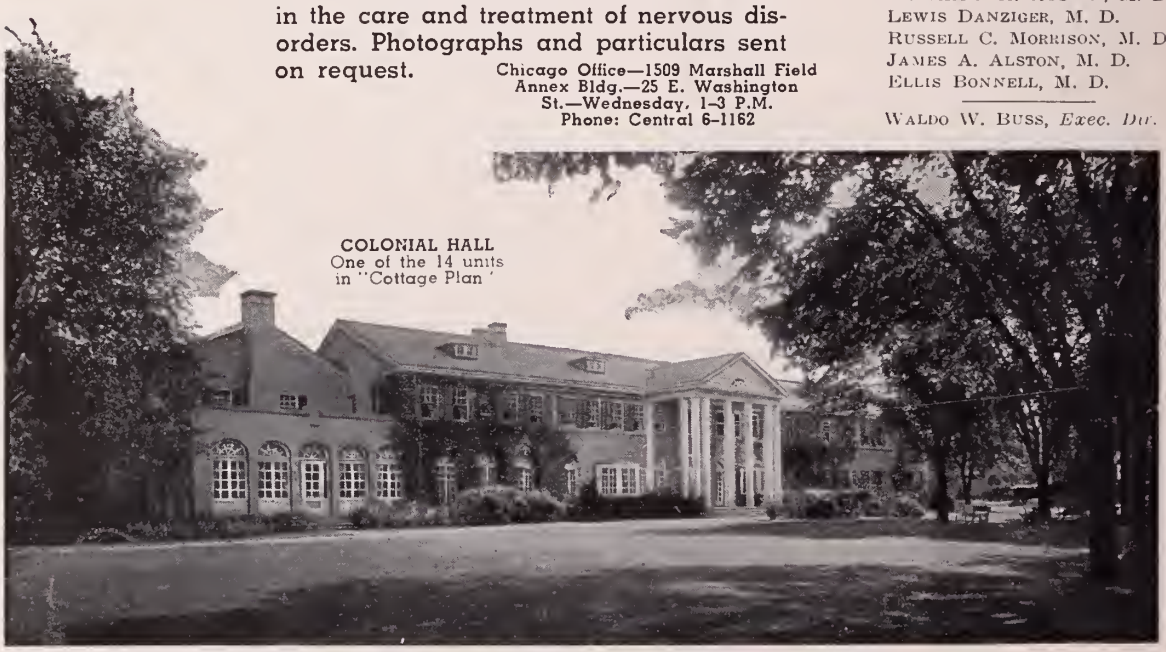

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Prevention of Allergic Reactions to Contrast Medium with Chlor-Trimeton, by Walter M. Kearns, M. D.	159
Management of Essential Hypertension, by Robert D. Taylor, M. D.	162
Therapeutic Trends in Lymph Node Tuberculosis, by John R. Spengler, M. D., and James M. Wilkie, M. D.	167
Climate and Cutaneous Cancer, by David Goe Welton, M. D.	170
Comments on Treatment	174
Clinicopathologic Conference	191
Civil Defense—Mobile Medical Teams	197

MISCELLANY

	Page
1956 Annual Meeting	183
Society Proceedings	206
News Items and Personals	224
Third and Twelfth Districts News	226
Society Records	229
Obituaries	232
Recent Wisconsin Licentiates	240
Facts About Wisconsin Physicians Service	242
The Journal Bookshelf	243
Physicians' Exchange	244
Index to Advertisers	246

EDITORIALS

	Page
The President's Page	200
Scientific Articles	203
Dependent's Day	203
Horsepower or Horse Sense	204

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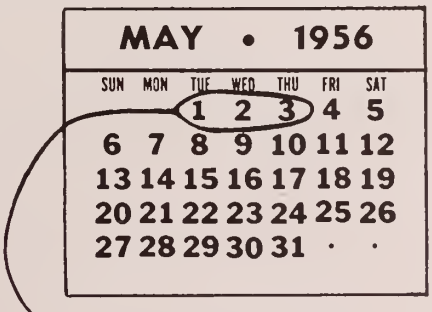

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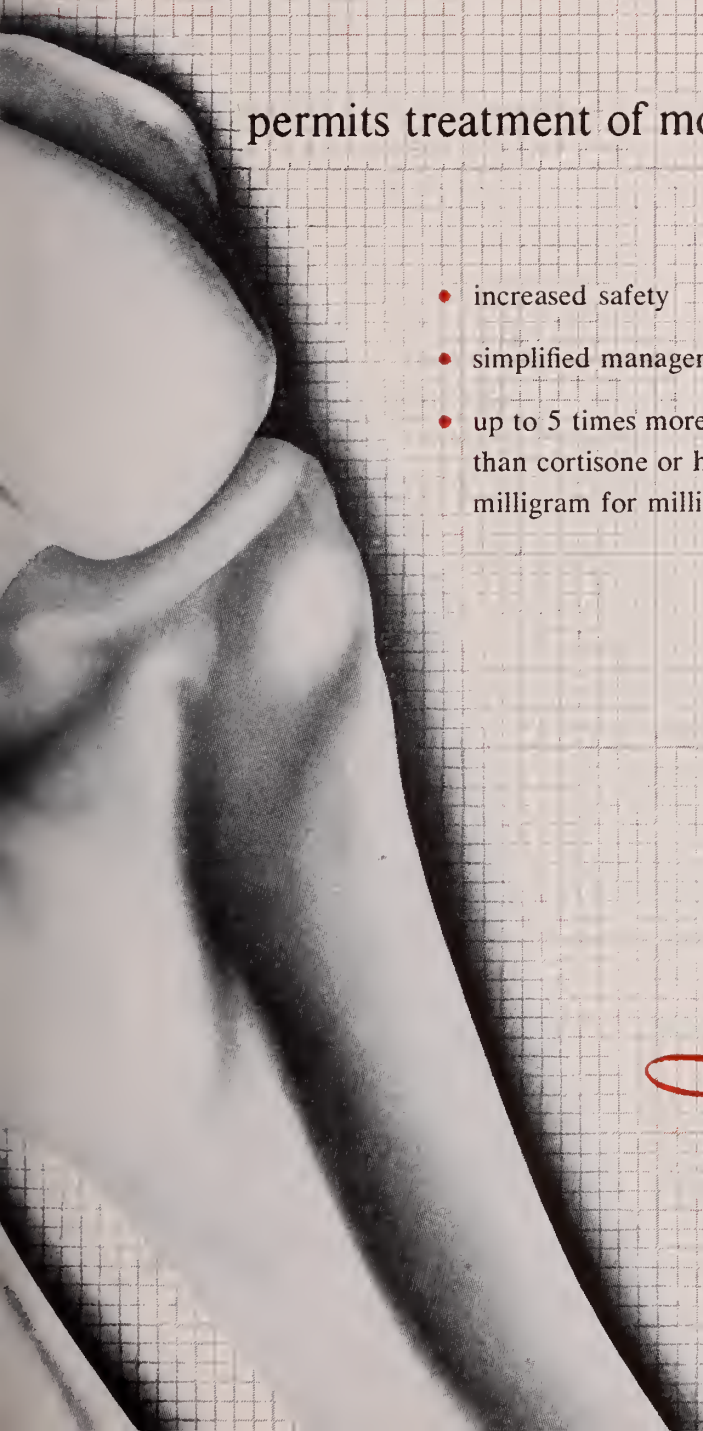

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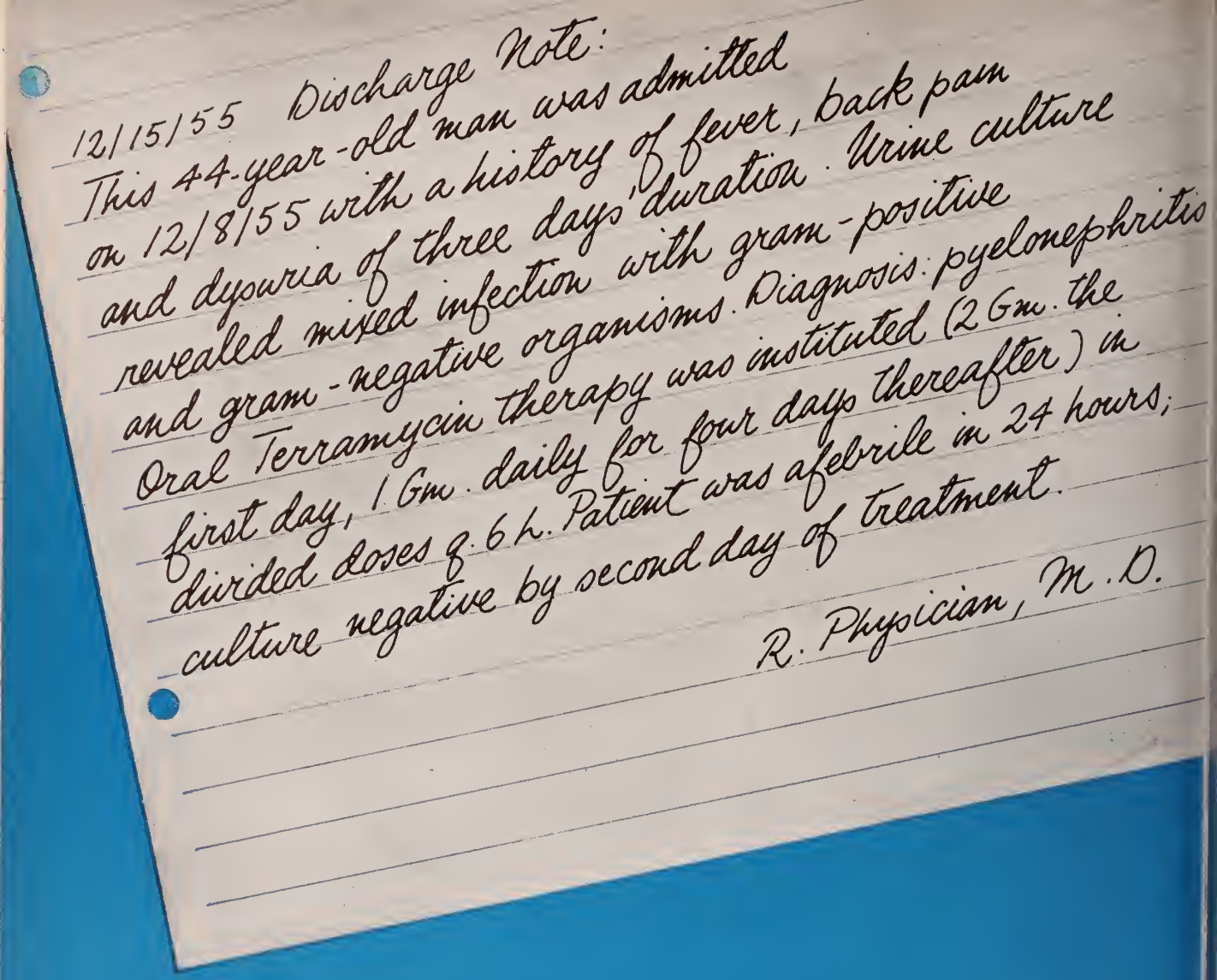

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DISCHARGE SUMMARY

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On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

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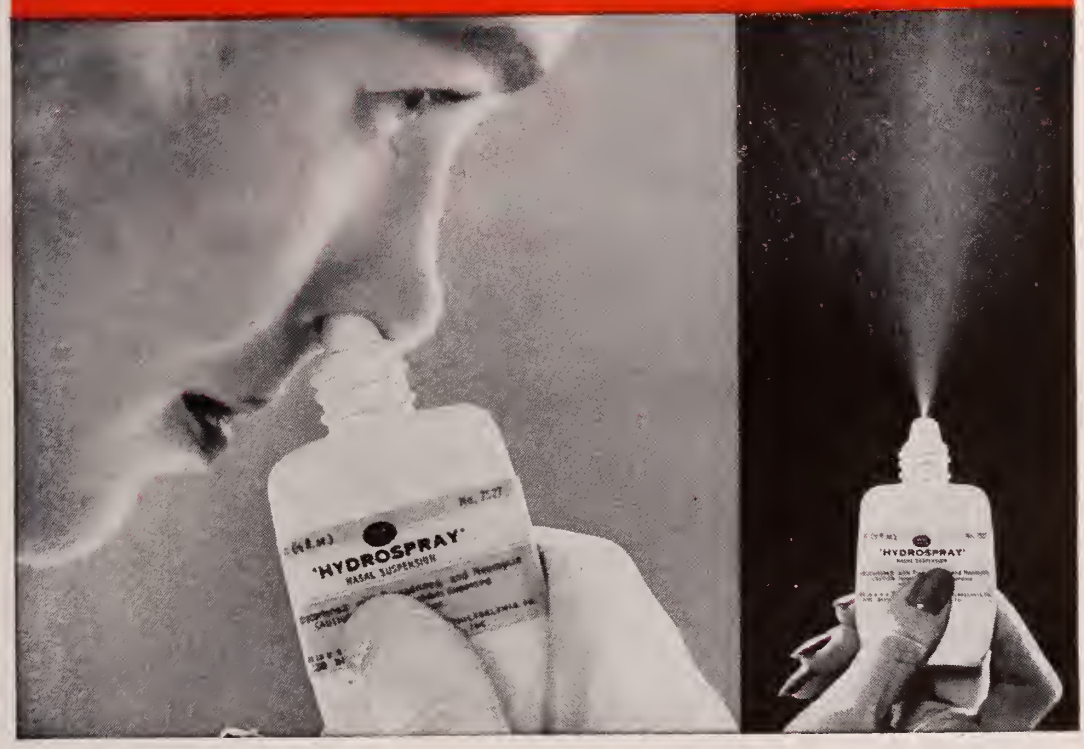

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THE WISCONSIN MEDICAL JOURNAL

Volume 55 FEBRUARY 1956 Number 2

Prevention of Allergic Reactions to Contrast Medium With Chlor-Trimeton

By WALTER M. KEARNS, M. D.
Milwaukee

IF IT were possible to predict accurately the occurrence of reactions to intravenous contrast media by preliminary testing, some of the danger in their administration would be avoided. Test doses themselves may provoke severe or even fatal reactions.[1,2]

The ocular, oral, and intradermal tests for sensitivity to contrast media have been discarded as unreliable.[3–5] However, these gestures are still carried out in many quarters for legal evidence of usual precaution, to be used in case of a severe untoward reaction leading to litigation. The reaction to an intravenous injection of a small test dose is not a satisfactory guide to predict the likelihood of sensitivity reactions. Armbruster and Hefke[6] reported complete absence of reactions to a 1 cc. test dose of intravenous agent in a series of 300 patients. When a full dose of the medium was later injected, 34 patients experienced an allergic type reaction. Similarly, Mullen and Hughes[4] demonstrated the inaccuracy of intravenous testing of contrast media, as they obtained only three positive reactions among 178 known allergic individuals. Some of their patients with negative tests and positive allergic histories had reactions following the usual doses of contrast media. Two lost consciousness following the administration of Diodrast. A history of allergy or idiosyncrasy to drugs is the all-important information in the preparation of the patient.

All sensitivity tests would be valueless in case of an anaphylactoid reaction without previous sensitization or injection of a substance. A test substance itself might precipitate such a reaction. Therefore, since reactions cannot be predicted, an attempt should be made to prevent them.

The danger in intravenous injection of a contrast medium lies in the possibility of occurrence of severe allergic or anaphylactoid reactions. Lesser allergic type reactions —urticaria, nausea, vomiting, dyspnea, sneezing, coughing, choking sensations— cause concern. The more severe—vertigo, bronchospasm, laryngospasm, edema of the eyelids, and shock—constitute real reasons for caution. Surveys[2,4] of immediate deaths due to intravenous urographic contrast media have revealed 42 deaths apparently due to hypersensitivity or idiosyncrasy to the media used. The incidence of milder allergic reactions to intravenous urographic media is about 17%.[5]

Antihistamines for Prevention of Allergic Reactions

As a means for preventing allergic reactions to intravenous contrast media, the oral administration of an antihistamine prior to injection of the substance has met with variable success.[7–9] The addition of an *injectable* antihistamine to the medium before injection appears to offer superior results in the prevention of this type of reaction. Olsson[10] and Moore and Sanders[11] investigated the use of Benadryl and Thenfadil parenterally and encountered 9.5% allergic type reactions; the reported incidence in unprotected patients is 17.3%.[5] Less satisfactory results were obtained with Benadryl by Bersack and Whitaker[12] and by Gilg.[13]

Simon, Berman, and Barald[14] added 5 mg. Chlor–Trimeton Maleate in solution to each dose of Neo-Iopax, Diodrast, or Urokon administered to 146 patients. Only mild allergic reactions occurred, and these were pres-

Incidence of Reactions to 50 and 75% Neo-Iopax with Added Chlor-Trimeton Maleate Injection

Dose and Injection Rate	Number of Patients	Age	Number of Patients With No Reaction	Reactions and Number of Cases of Each	
			Neo-Iopax 50%		
20 cc. in 45 sec.	1	6	1		
20 cc. in 1 min.	1	5	1		
30 cc. in ½ min.	1	54	1		
30 cc. in 1 min.	113(a)	16–82	105	Slight arm pain	1
				Slight shoulder pain	1
				Severe arm and shoulder pain	1
				Slight sensation of warmth	4
				Syncope	2
				Nausea	1
			Neo-Iopax 75%		
20 cc. in 30 sec.	1	10	1		
20 cc. in 1 min.	1	17	...	Shoulder pain (b)	1
25 cc. in 45 sec.	1	43	1		
25 cc. in 1 min.	1	33	1		
30 cc. in 1 min.	5	24–62	5		
Totals	125		116 (92.8%)	Pain on injection	4 (3.2%)
				Vasomotor	4 (3.2%)
				Syncope	2 (1.6%)
				Nausea	1 (0.8%)
					11 (8.8%)(c)

(a) Includes 6 hypersensitive patients—3 to Neo-Iopax, 3 to Diodrast.
(b) Not present with Neo-Iopax 50%.
(c) Two patients had 2 side actions each.

ent in only 4% of their patients. In another series of 530 patients receiving these urographic media, with 5 or 6 mg. Chlor-Trimeton Maleate in solution, all reactions were mild.[5] Allergic type reactions occurred in 7.3% of the patients, which represents a reduction of 10 percentage points below the rate of such reactions in patients receiving media without antihistamine.

Winter[15] added 10 mg. Chlor-Trimeton Maleate to each 25 cc. dose of Urokon administered to 450 patients and markedly reduced the incidence of urticaria and nausea attendant upon the use of this drug. Munger[16] uses 10 mg. Chlor-Trimeton in children with an allergic history when it is planned to inject Urokon for urographic examinations.

Materials and Method

We use Neo–Iopax routinely for intravenous urography as the safest and best shadow-casting preparation.[17, 18] Allergic reactions to this substance, as seen in large groups of patients, occur at the rate of about 12%, as follows: urticaria 0.09%, vomiting 2.4%, nausea 8.1%, vertigo 1.2%, and respiratory symptoms (dyspnea, sneezing) 0.3%.[4, 6, 19, 20]

In a series of 125 patients receiving Neo-Iopax, 50 or 75% in doses of 20 to 30 cc., 10 mg. Chlor-Trimeton Maleate in solution* for intravenous injection was added to each dose of medium prior to intravenous injection. Three patients were children, and smaller doses of medium were administered to them.

As the accompanying table shows, the majority of the patients received 30 cc. of a 50% Neo-Iopax solution injected in one minute. The rate of injection may have affected the incidence of arm pain and possibly vasomotor phenomena but not the incidence of allergic reactions. Among the 113 patients receiving this dose were 6 patients who had had previous reactions; 3 of them had had reactions to Neo-Iopax and 3 to Diodrast. Except in one patient who had received Diodrast, these reactions were the allergic type.

Results

No reactions of any kind occurred in 116 (92.8%) of the 125 patients receiving Neo-Iopax with 10 mg. Chlor-Trimeton in solution in the same syringe. Four patients had pain in the arm or shoulder, and 4 had a slight sensation of warmth. Reactions of an

*Chlor-Trimeton Maleate Injection 10 mg./cc. was furnished by George Babcock, Jr., M. D., Division of Clinical Research, Schering Corporation, Bloomfield, New Jersey.

allergic nature consisted of syncope, which accompanied slight flushing in an emotional patient, and syncope and nausea in an elderly man.

The 3 patients hypersensitive to Neo-Iopax had previously exhibited hives, flushing, and nausea, alone or in combination, following a dose of the substance. When they were protected with Chlor-Trimeton, no reactions occurred. Similarly, the 3 patients who had reacted to Diodrast with extreme warmth, nausea, severe arm pain, and extreme flushing had no side effects from Neo-Iopax with the added antihistamine.

All 3 of the children receiving Neo-Iopax with Chlor-Trimeton were free of side actions.

The low rate of allergic reaction (2.4%) represents a reduction from the overall incidence of allergic reactions reported with Neo-Iopax—12%. The reduction in nausea, based on available comparative data, was significant—the rate in previous large series of unprotected patients was 8.1%, and in this group, it was 0.8 per cent.

Summary

Ten milligrams Chlor-Trimeton Maleate in solution for intravenous injection was added to each 20 or 30 cc. dose of 50 or 75% Neo-Iopax injected into 125 patients for urographic examination. Only 3 allergic type reactions occurred—2 cases of syncope and 1 of nausea. This low rate of allergic reaction to Neo-Iopax with Chlor-Trimeton, 2.4%, contrasts with a rate of about 12% among large series of patients not protected with the antihistamine. No side actions due to Chlor-Trimeton were encountered. This study indicates that Chlor-Trimeton Maleate is highly effective in preventing allergic reactions to intravenous urographic media.

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REFERENCES

1. Dolan, L. P.: Allergic death due to intravenous use of Diodrast; suggestions for possible prevention, J.A.M.A. 114:138–139 (Jan. 13) 1940.
2. Pendergrass, E. P., Hodes, P. J., Tondreau, R. L., Powell, C. C., and Burdick, E. D.: Further consideration of deaths and unfavorable sequelae following administration of contrast media in urography in the United States, Acta Radiol., Suppl. 116, pp. 84–93, 1954.
3. American Medical Association: New and Nonofficial Remedies 1954, Philadelphia, J. B. Lippincott Company, 1954, p. 336.
4. Mullen, W. H., Jr., and Hughes, C. R.: Intravenous urographic contrast media; controlled study of Diodrast and Neo-Iopax, Am. J. Roentgenol. 68:903–914 (Dec.) 1952.
5. Simon, S. W., Berman, H. I., and Rosenblum, S. A.: Prevention of reactions in intravenous urography, J. Allergy 25:395–399 (Sept.) 1954.
6. Armbruster, J. L., and Hefke, H. W.: Neo-Iopax: relationship between degree of reactions and time of intravenous injection, Am. J. Roentgenol. 68:915–917 (Dec.) 1952.
7. Getzoff, P. L.: Use of antihistamine drug prophylaxis against Diodrast reactions, J. Urol. 65: 1139–1142 (June) 1951.
8. Crepea, S. B., Allanson, J. C., and DeLambre, L.: Failure of antihistaminic drugs to inhibit Diodrast reactions, New York State J. Med. 49 2556–2558 (Nov. 1) 1949.
9. Nesbit, R. M., and Lapides, J.: Observations on Urokon, new excretory pyelographic medium, Univ. Michigan M. Bull. 16:37–42 (Feb.) 1950.
10. Olsson, O.: Antihistaminic drugs for inhibiting untoward reactions to injections of contrast medium, Acta Radiol. 35:65–70 (Jan.) 1951.
11. Moore, T. D., and Sanders, N.: Reaction to urographic agents with and without antihistamines, J. Urol. 70:538–544 (Sept.) 1953.
12. Bersack, S. R., and Whitaker, T. E., Jr.: Effect of diphenhydramine (Benadryl) on side-reactions in intravenous urography, A.M.A. Arch. Int. Med. 91:618–625 (May) 1953.
13. Gilg, E.: Influence of diphenhydramine (Benadryl) on the side effects of diodone in urography, Acta Radiol. 39:299–307 (Jan.–June) 1953.
14. Simon, S. W., Berman, H. I., and Barald, F. C.: Prevention of reactions in intravenous urography (preliminary report), Ohio M. J. 50:247–248 (March) 1954.
15. Winter, C. C.: Value of Chlor-Trimeton in prevention of immediate reactions to 70% Urokon, Read at West. Sect. Meet. (Coronado, California), Am. Urol. Assoc., Jan. 24–27, 1955.
16. Munger, H. V.: Advances in care of common pediatric urological problems, J. Arkansas M. Soc. 51:156–160 (Dec.) 1954.
17. Kearns, W. M., Hefke, H., and Morton, S. A.: Ditopax—new excretory urographic medium; clinical report on 1,280 injections, J. Urol. 56:392–398 (Sept.) 1946.
18. Kearns, W. M.: Aortography and pneumography, Wisconsin M. J. 53:139–142 (Feb.) 1954.
19. Friedman, L. J., Lobsenz, H., and Jauernig, R.: Pyelography by rapid injection; description of improved method and results in 200 cases, Am. J. Roentgenol. 62:84–90 (July) 1949.
20. Friedman, L. J., Friedenberg, R., and Love, L.: Intravenous urography by rapid injection; further results with improved method, Am. J. Roentgenol. 69:433–441 (March) 1953.

Management of Essential Hypertension

By ROBERT D. TAYLOR, M. D.
Marshfield

Introduction

MANAGEMENT of hypertensive disease in the past five years has changed so that the science of medicine is almost as important as patient-physician relationship. It has been repeatedly demonstrated by the effects of sympathectomy,[1] sodium restriction,[2-4] kidney extracts,[5] and pyrogens[6] that sustained reduction of elevated arterial blood pressure has a beneficial effect upon the vessel disease of hypertension. There are now several drugs capable of reducing pressure in some hypertensive patients. Each has its shortcomings, and some can be dangerous to health and life. This discussion is a digest of experiences during ten years of association with Irvine H. Page and A. C. Corcoran at the Cleveland Clinic and is presented with the hope it will help to save practitioners some unnecessary experimentation with potent hypotensive agents.

Selection of Patients to Be Treated

Arteriosclerotic Hypertension. This classification includes a large percentage of patients with high blood pressure. These patients are usually more than 50 years of age and have predominantly systolic hypertension. Many are obese and thus have increased cardiac output, which contributes to their comparatively benign hypertension. The pressure fluctuates widely; and there are clinical and x-ray signs of loss of elasticity of the large arteries such as the aorta, and the brachial, carotid, and femoral vessels.

The newer hypotensive drugs have actions that are ineffective in such a physiological state and can do harm. The orthostatic hypotension often associated with the ganglion blocking agents may precipitate thrombosis in those with cerebral and coronary arteriosclerosis. In older males, paralysis of the parasympathetic supply to the bladder often precipitates urinary retention. Tendencies to paralytic ileus are greater in older people. Hydralazine probably acts by inhibiting the formation of a vasopressor substance of cerebral origin;[7] there is no evidence that this is present in excess in this group of patients. Further, the tachycardia incident to initiation of treatment with this drug has been shown to bring on congestive failure and possibly myocardial infarction in patients beyond 50 years of age.[8]

Derivatives of veratrum viride produce abrupt falls of pressure and thus considerable theoretical danger to the coronary circulation. More important, however, is the increasing evidence that these drugs do not have a place in the treatment of any variety of hypertension. In our experience, the dose that is capable of reducing blood pressure is almost identical to that which causes emesis. Since vomiting seemed to be the major limiting factor in the use of these drugs, we gave them in conjunction with the antiemetic, Thorazine. However, as in experimental emesis induced with veratrum in dogs, no impressive antiemetic action was observed. We found no clinical differences in using the various alkaloids available.

For these patients with arteriosclerotic hypertension, the simple and usually safe drug, phenobarbital, given 16 to 32 mg. four times daily, is almost "specific." Giddiness, headache, and insomnia are controlled; and usually the pressure is reduced to normal for patients in this age group.

Early Essential Hypertension. Hypertension, whether of long or short duration, can be considered early when it is not attended by symptoms or signs of vascular disease. It is our belief that patients with this type of hypertension should not be treated with the new hypotensive drugs. First, some of them will live a normal span of years with no treatment; it is impossible at one examination, however complete, to separate these from patients who will have progressive vascular disease. Next, some of these drugs can do considerable harm. Hydralazine, given in large doses over long periods, was shown to cause, in 10% of one group,[9] a rheumatic and febrile syndrome indistinguishable from systemic lupus erythematosus. In a few patients receiving hexamethonium over many months a progressive and fatal pulmonary fibrosis occurred.[10] Rauwolfia serpentina products

have not been used long enough for us to know if serious side reactions occur; but these drugs can produce unpleasant nasal congestion and diarrhea, and in some patients attendant weakness and fatigue prevent normal work. Finally, development of tolerance to some of these drugs is frequent. It is possible that patients with early hypertension may, in the future, need the effects of these hypotensive agents badly; if tolerance has already appeared, they are deprived of the months or years of blood pressure control which might arrest progressive vascular change. Our policy is to appraise the vascular bed of those with compensated essential hypertension to form a base line to be used for comparisons when similar observations are made at intervals of nine to twelve months. In the meantime, patients lead a normal life, with cautions against excessive weight gain and unnecessary expenditure of physical and emotional energy. If any of these examinations produce evidence of vascular deterioration, treatment is begun.

Essential Hypertension with Signs of Vascular Deterioration. If signs of the malignant syndrome (papilledema with hemorrhagic retinopathy, proteinuria) appear, prompt and reasonably standard treatment is instituted. This will be discussed in a later section. The majority of patients who develop signs of vascular decompensation present less fulminant symptoms such as headaches, insomnia, increasing retinal arteriolar sclerosis, scattered retinal hemorrhages, increasing heart size, or gradually lessening renal reserve. Among such patients there is sufficient time to select the simplest, most effective treatment by a process of elimination, starting with the least complicated.

Selection of Therapy

Thiocyanate. This much-maligned and often-forgotten drug, in our hands, has been very useful, particularly in those who suffer from hypertensive headache and insomnia. We have found that, when combined with phenobarbital, the drug has produced good results with serum concentrations of 3 to 6 mg. per 100 ml. as compared with the 8 to 12 mg. levels Barker[11] found necessary when using thiocyanate alone. This reduces the frequency of toxic reactions and permits fewer measurements of blood levels. We prescribe the drug in the form of the elixir of the sodium salt with equal parts of elixir of phenobarbital, to be taken 4 ml. three to four times daily. Once it is established that this dosage is adequate and safe, the blood level can be measured at three to four-month intervals.

The above program controls approximately 80% of headaches due to hypertension; and although thiocyanate has never been shown to have a specific hypotensive action, the pressure of 25 to 30% of patients is favorably influenced, possibly because of the analgesic and mild sedative action of the drug.[12]

Derivatives of Rauwolfia Serpentina. In patients without headache or in whom thiocyanate is ineffective, these preparations are often surprisingly effective. Contrary to oft-repeated statements of the manufacturers, suggesting that these drugs are indicated only in those with mild hypertensive disease, we have shown they can be dramatically helpful even in some with the malignant syndrome.[13] In those who respond, the action seems almost specific; and the pressure is usually restored to normal with regression of signs of vascular disease.

As far as is known, the hypotensive effects of drugs prepared from these roots depend upon the alkaloid, reserpine. This is contained in all the commercial preparations; and to our knowledge, none has advantage over another. The size of the tablets varies from 50 mg. for those made from the whole root to 0.1 mg. for some containing only the pure alkaloid. Treatment is started with any of these given four times daily for a period of at least three weeks. If after this time there is not significant lowering of pressure, other treatment should be considered. If the pressure is reduced, dosage can be lessened to the minimum amount that will maintain maximum control of pressure. In many instances, this will be as little as one tablet per day.

Hydralazine. Because this drug is difficult to use and sometimes causes serious changes of collagenous tissue in the body,[8, 9] it is reserved for those who do not respond to the above two agents. When properly used, it will restore the blood pressure to normal in 35% of hypertensive patients and maintain the diastolic pressure at less than 110 mm. Hg. in another 30%.[8] Because of side reactions, which have been described earlier, it must be given in slowly increased amounts. We start with 25 mg. four times per day and

increase the dosage by 50 to 100 mg. a day, every three or four days as permitted by the patient's symptoms, until the pressure is reduced to normal or until the patient is taking 600 to 800 mg. daily. Since some of our best results were observed after four weeks of treatment, we do not abandon the drug until after five weeks. In those who have good responses, the dosage is gradually reduced to the minimum that will hold the pressure at maximally low levels. This may be 100 to 200 mg. per day.

We have been unable to show advantage from combining hydralazine with other hypotensive agents. However, the combination of ganglion blocking agents and Rauwolfia preparations may sometimes have value.

Ganglion Blocking Agents. Use of these drugs for long-term treatment of hypertensive disease is possible only in those patients who are emotionally and intellectually capable of assuming the inconvenience and responsibility of determining dosage by measurement of their own blood pressure in the lying and upright positions four times daily and recognizing and counteracting the signs of parasympathetic paralysis.[10] If these criteria are not met, sodium restriction or sympathectomy should be used. They will be considered in another section.

Ansolysen (pentolinium tartrate) is probably an improvement over hexamethonium. It generally has a slightly longer action than the older drug; smaller doses are used and in many patients the effects on the bowel are less troublesome. However, there are some who prefer hexamethonium. Currently there is an orally active ganglion blocker under investigation, one 100 mg. tablet of which will control the pressure of some patients for as long as 24 hours. Continued study will doubtless produce more effective and safer drugs of this type. In the meantime, most investigators believe that treatment with these drugs should be started in the hospital.

Details of treatment have been published by several authors. [14, 15] The objective is to establish the amount of oral or injectable drug necessary to maintain the blood pressure, in the upright position, as close to 120/80 mm. Hg. as possible. Rarely is the supine pressure significantly reduced for more than a few weeks. The dosage for each six or eight-hour period is rarely the same and must be determined by measurement of pressure at the time medication is due. Appropriate use of saline cathartics, cascara, and Urecholine to assure a daily bowel movement is an integral part of management. Overtreatment of the bowel sometimes causes diarrhea. In this instance, the hypotensive action of the drugs is for some reason enhanced; and overdosage during these periods is to be avoided.

It is possible to control the upright pressure of 60 to 75% of this group of patients with this program. The oral dosage of hexamethonium varies between 500 to 1,500 mg. every four hours. Ansolysen is usually effective when given 100 to 400 mg. every six hours.

There is increasing evidence that, for patients who do not respond to treatment with blocking agents alone, the addition of a Rauwolfia derivative will effect reduction of the pressure. Also, as the two are given in combination, the amount of blocker needed may gradually lessen until the dose is one-third of that which was only partially effective when given alone.

For those with advancing vascular disease who are for one reason or another rejected for treatment with the above drugs, severe sodium restriction or sympathectomy can be tried.

Dietary Treatment. Low sodium diets have several disadvantages. They are not palatable and are effective in only about 25% of hypertensive patients.[4] The intake of sodium must be less than 500 mg. per day. Because of the omnipresence of sodium and the frailties of human beings, measurement of the output of urinary sodium at appropriate intervals is the only means of establishing that therapy is adequate. For those who respond with reduction of blood pressure and who can adjust to the rigid dietary requirements, this is a safe and valuable form of treatment.

Sympathectomy. The operative treatment of hypertension currently has about the same limitations that were described 17 years ago.[1] These are: 1. There is no means, short of operation, that will select the patients who will get a good result; 2. Not more than 10 to 12% will have excellent results with long-term regression of all signs of disease. However, another 45 to 50% are greatly helped by relief of symptoms and have an increased life expectancy. These gains are believed to be due to orthostatic hypotension and lessening of the overshoots

of pressure that accompany the efforts and agonies of living.

Management of Malignant Syndrome

When the signs of vascular failure constitute the malignant syndrome (papilledema, hemorrhagic retinopathy, proteinuria, and hematuria), dependable and established routines of treatment should be instituted as soon as possible after the diagnosis is established. Since most of such patients have some element of hypertensive heart disease and many have actual congestive failure, we limit the dietary sodium to 1,000 mg. per day. If there are evidences of renal failure, appropriate dietary and medicinal treatment is prescribed. A ganglion blocking agent is started, usually by intramuscular injection. If there is azotemia, the blood pressure must be reduced slowly for in some patients sudden reduction of filtration pressure results in decreased urinary output and severe uremia. Dosage is adjusted so that the standing blood pressure is as near 120/80 mm. Hg. as possible. Attention to fecal elimination is routine.

With the hope that long-term treatment can be carried on with one of the less complicated drugs, these patients are simultaneously started on a Rauwolfia preparation. When the signs of malignancy are controlled, the blocker is gradually discontinued. If the reduction of pressure is maintained, the patient is discharged with only the simpler drug. If the pressure rises to pretreatment levels, hydralazine is offered. If that is not effective, plans for long-term treatment with a blocking agent are made.

With this approach to the management of hypertensive vascular disease, we have been able to influence favorably the course of the disease in 85% of patients with decompensating essential hypertension.

Summary

1. If patients are followed with careful appraisal of the vascular tree at intervals of 9 to 12 months, it is safe to withhold treatment in patients with essential hypertension until they have distressing symptoms or show signs of vascular deterioration.

2. In the absence of signs of the malignant syndrome, the simplest treatment should be tried first with progression to more complicated and dangerous agents only if necessary for control of blood pressure.

3. Elixir of sodium thiocyanate with equal parts of elixir of phenobarbital, 4 ml. three to four times daily, in the presence of adequate renal function, will produce serum levels of 3 to 6 mg. per 100 ml. These concentrations control hypertensive headache in about 80% of patients and reduce the blood pressure in 25 to 30%.

4. Derivatives of Rauwolfia serpentina are sometimes dramatically effective in patients with severe hypertensive disease.

5. Hydralazine, given with care and realization that it can produce severe collagenous disease, will control the pressure of 60% of hypertensive patients.

6. Ganglion blocking agents should be used in only those patients emotionally and intellectually geared to accepting responsibility for measuring their own blood pressures and regulating dosage and parasympathetic paralysis. Dosage must be adequate to maintain standing blood pressure near 120/80 mm. Hg.

7. Low sodium diets are not palatable, and are tedious. Also, their adequacy must be established by weekly measurement for 24-hour urinary sodium. Daily intake of sodium should be less than 500 mg. This treatment is effective in about 25% of patients.

8. Sympathectomy has as its major limitation our inability to select good responders before operation. It is dramatically effective in 10 to 12% and of value in 40 to 50% more patients.

9. The malignant syndrome should be treated with low sodium diet and ganglion blocking agents. Simultaneously, less complicated treatment is begun for long-term management after signs of necrotizing arteriolitis are controlled.

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REFERENCES

1. Page, I. H.: Pathogenesis of arterial hypertension, J.A.M.A. 140:451–458 (June 4) 1949.
2. Allen, F. M.: Arterial hypertension, J.A.M.A. 74:652–655 (March 6) 1920.
3. Kempner, W.: Treatment of kidney disease and hypertensive vascular disease with rice diet, North Carolina M. J. 5:125–133 (April) 1944.
4. Corcoran, A. C., Taylor, R. D., and Page, I. H.: Controlled observations on effect of low sodium dietotherapy in essential hypertension, Circulation 3:1–16 (Jan.) 1951.
5. Page, I. H., Helmer, O. M., Kohlstaedt, K. G., Kempf, G. F., Corcoran, A. C., and Taylor, R. D.: Progress report of investigations concerned with experimental treatment of hypertension with kidney extracts, Ann. Int. Med. 18:29–42 (Jan.) 1943.

6. Page, I. H., and Taylor, R. D.: Pyrogens in treatment of malignant hypertension. Mod. Concepts Cardiovas. Dis. 18:51–52 (Oct.) 1949.

7. Taylor, R. D., Page, I. H., and Corcoran, A. C.: Hormonal neurogenic vasopressor mechanism, A.M.A. Arch. Int. Med. 88:1–8 (July) 1951.

8. Taylor, R. D., Dustan, H. P., Corcoran, A. C., and Page, I. H.: Evaluation of 1-hydrazinophthalazine ("Apresoline") in treatment of hypertensive disease, A.M.A. Arch. Int. Med. 90:734–749 (Dec.) 1952.

9. Dustan, H. P., Taylor, R. D., Corcoran, A. C., and Page, I. H.: Rheumatic and febrile syndrome during prolonged hydralazine treatment, J.A.M.A. 154:23–29 (Jan. 2) 1954.

10. Corcoran, A. C., Dustan, H. P., Taylor, R. D., and Page, I. H.: Management of hypertensive disease, Am. J. Med. 17:383–394 (Sept.) 1954.

11. Barker, M. H.: Blood cyanates in treatment of hypertension, J.A.M.A. 106:762–767 (March 7) 1936.

12. Thomas, C. B.: What is mode of action of thiocyanate compounds in essential hypertension? Ann. Int. Med. 37:106–122 (July) 1952.

13. Dustan, H. P., Taylor, R. D., Corcoran, A. C., and Page, I. H.: Clinical experience with reserpine (Serpasil): controlled study, Ann. New York Acad. Sc. 59:136–140 (April 30) 1954.

14. Locket, S., Swann, P. G., and Grieve, W. S. M.: Methonium compounds in treatment of hypertension, Brit. M. J. 1:778–784 (April 14) 1951.

15. Smirk, F. H., and Alstad, K. S.: Treatment of arterial hypertension by penta- and hexamethonium salts based on 150 tests on hypertensives of varied aetiology and 53 patients treated for periods of 2 to 14 months, Brit. M. J. 1:1217–1228 (June 2) 1951.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1956 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic. Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify number of forms wanted and for which clinic they are wanted. Families who return the signed referral form will be notified of the day and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

Location	*Date*
Green Bay	March 1
	March 2
Kenosha	March 7
	March 8
Eau Claire	March 15, 16
Racine	March 21, 22
Wausau	March 28, 29
Superior	April 5, 6
Sheboygan	April 11, 12
Marinette	April 18
La Crosse	April 24, 25
	April 26, 27
Appleton	May 10, 11
Fond du Lac	May 16
Chippewa Falls	May 23, 24
Rhinelander	June 5, 6
Lancaster	July 19
Darlington	July 20
Eau Claire	July 26, 27

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

Therapeutic Trends in Lymph Node Tuberculosis*

By JOHN R. SPENGLER, M. D.,** and JAMES M. WILKIE, M. D., F. A. C. P.***
Madisan

Introduction

RECENT studies of chemotherapy in tuberculosis have largely emphasized the management of pulmonary tuberculosis. There are few reports of the effect of long-term therapy on lymph node tuberculosis. Prior to the advent of highly effective specific antibiotic therapy, three approaches to the management of this disease were held to be effective. These were (1) roentgen therapy, (2) surgical excision or drainage, and (3) chemotherapy.

Some authors report a curative effect with x-ray therapy. However, the disease is usually not irradicated and complications are frequent. These complications, such as fibrosis of the skin and underlying tissues, malignant degeneration, and occasional x-ray burn, are not infrequent. In resistant cases with draining sinuses, the use of x-ray is, nevertheless, considered to be of some value. In a report by Aceto, Kasuga, and Sanderson,[1] 63% of the cases having fluctuant nodes and/or draining sinuses responded to therapy.

Many chemical agents have been employed in the therapeutic management of tuberculosis of the lymph nodes. These medications have been employed locally as well as systemically.

Local installation of PAS, Promanide,[2] and streptokinase and streptodornase[3, 4] has been used with encouraging results. The nodes involved were fluctuant; and, subsequent to aspiration, draining sinuses, which eventually closed, generally developed.

Recently, a variety of systemic drugs have been employed. Sodium salicylate has been recommended by Engle,[5] who claims favorable results. Substantiation of this has not been forthcoming.

Wide-scale usage of streptomycin began in 1947. This was followed by the use of adjunct therapy with para-aminosalicylic acid in 1949. Viomycin became available in 1951 and isoniazid in 1952.[6]

Gray[7] reported the advantageous effects of streptomycin in the treatment of tuberculosis of the lymph nodes in April, 1950. The beneficial effects of streptomycin in resolution of lymph node tuberculosis and closure of sinus tracts was appreciated; however, a number of failures were experienced following the development of resistant acid-fast bacterial strains, and therefore caution was advised.

In March, 1953, Cordice, Hill, and Wright[8] noted the beneficial effects of pyrazinamide in the treatment of tuberculosis of the lymph nodes. Short-range therapy was employed with excellent results. Sinus tract closure and diminution in size of involved nodes exemplified the therapeutic response.

Lester[9] emphasized the necessity of employing good surgical judgment in the treatment of tuberculosis of the lymph nodes. Dissection of cold abscesses which failed to respond to medical management was offered as a suggestion. In addition, adequate antimicrobial therapy as a prelude to surgery was stressed.

Present Study

The present study was designed to investigate the efficacy of adequate bed rest and antimicrobial therapy in the treatment of lymph node tuberculosis. Surgical intervention, with removal of deep-seated, caseous, nonresolving foci and drainage of fluctuant nodes, was used as adjunctive treatment where indicated.

Data Analysis

Sixteen patients were included in this study. The data obtained were classified under the following headings: age, sex, and race; site of lymph node involvement; concurrent tuberculous disease; effect of treatment; duration of hospitalization; antimicrobial therapy; ancillary measures; and the therapeutic response.

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TABLE 1

Case No.	Age, Sex, Race	Lymph Nodes Involved	Concurrent Disease (tbc)	Effect of Treatment	Duration of Hospitalization	Antimicrobial Therapy	Ancillary Measures	Results
1	H. P. 29 yrs N/M	Supraclavicular Left	Pul., Min.	Diminished in size	7 mos.*	SM PAS	None	Improved
2	C. C. 32 yrs. N/M	Supraclavicular Left	Pul., Far Adv.	Diminished in size	16 mos.	INH SM PAS	Incision and Drainage	Improved
3	E. H. 36 yrs. N/M	Axillary, Left Inguinal Mediastinal	Pul., Far Adv.	Diminished in size Closure of sinus tract	19 mos.	INH SM PAS	None	Improved
4	C. C. 45 yrs. W/M	Cervical, Bil. Supraclavicular Right	Pul., Far Adv.	Diminished in size	6 mos. Left Against Med. Adv.	INH SM PAS	None	Improved
5	J. M. 34 yrs. N/M	Cervical, Left Submandib., Rt. Tonsillar, Rt.	Pul., Min.	Complete resolution	17 mos.	TM SM PAS	None	Cured
6	J. C. 29 yrs. W/M	Cervical, Bil. Axillary, Bil.	Pleurisy	Diminished in size Closure of sinus tract	13 mos.	INH SM	None	Improved
7	J. H. 32 yrs. N/M	Cervical, Bil.	None	Diminished in size Closure of sinus tract	15 mos.	INH SM PAS	Incision and Drainage	Improved
8	W. D. 32 yrs. N/M	Cervical, Bil.	None	Diminished in size	10 mos.	INH SM PAS	None	Improved
9	C. R. 35 yrs. N/M	Cervical, Bil. Axillary, Right	Pul., Mod. Adv.	No change in size	10 mos.	TM SM PAS	None	Improved
10	C. G. 28 yrs. N/M	Supraclavicular Bil.	Hematogenous Spread	Diminished in size	14 mos.	SM PAS	None	Improved
11	E. H. 26 yrs. N/M	Cervical, Bil. Supraclavicular Right	Pul., Min.	Complete resolution	14 mos.	INH SM PAS	None	Cured
12	W. W. 26 yrs. N/M	Supraclavicular Right	None	Complete resolution	14 mos.	SM PAS	None	Cured
13	F. O. 32 yrs. W/M	Cervical, Bil. Axillary, Right	Hematogenous Spread	Diminished in size	6 mos.*	INH SM PAS	None	Improved
14	C. L. 26 yrs. N/M	Cervical, Bil.	None	Diminished in size	12 mos.	SM PAS	Excision	Improved
15	W. D. 23 yrs. N/M	Cervical, Bil.	Hematogenous Spread	No change Sinus tract open	18 mos.	SM PM PAS INH VM	None	Unimproved
16	G. H. 25 yrs. N/M	Supraclavicular Right	Pul. Lymphogenous	Diminished in size	4 mos.*	SM PAS INH	None	Improved

*Still in hospital.

The diagnosis was established by biopsy in each case

Key to therapy
SM—Streptomycin
INH—Isoniazid
PAS—Para-aminosalicylic Acid
VM—Viomycin
TM—Terramycin
PM—Promin

Thirteen of the sixteen patients in this series were Negroes. All patients were males. The age range was from 23 to 45 years, with a mean age of 31 years.

The diagnosis was established by biopsy with acid-fast bacilli isolation in 15 cases, while one diagnosis was established by acid-fast bacilli isolation on aspiration of a fluctuant lymph node. The most frequent sites of involvement were: (1) cervical lymph glands—11 cases, (2) supraclavicular lymph glands—7 cases, and (3) axillary lymph glands—4 cases.

Associated pulmonary tuberculosis was noted in 9 of the cases. Pulmonary disease ranged from minimal to far advanced disease. No evidence of either pulmonary tuberculosis or disseminated hematogenous disease was reported in 4 of the cases. Hematogenous dissemination was present in 3 cases.

In 11 cases the nodes diminished in size, with closure of sinus tracts when present (3

cases). Complete resolution of lymph node involvement was reported in 3 cases. Stability of the lymph node tuberculosis without change in the size of the nodes or resolution was reported in 1 case; in this case resolution of the pulmonary tuberculosis was noted. No apparent change in size of the lymph nodes or closure of the sinus tract was noted in this case.

In the analysis of the mean duration of hospitalization with antimicrobial therapy, 3 patients still in the hospital and 1 who left against medical advice were eliminated. The mean duration of hospitalization was 14.3 months. Antimicrobial therapy was given during this time and continued on an outpatient basis. The patients returned at three-month intervals for follow-up examinations.

The chemotherapy dosage and distribution was not uniform. Eight patients received the antimicrobial therapy program of isoniazid, para-aminosalicylic acid, and streptomycin, while four of the patients received PAS and streptomycin. One patient received isoniazid and streptomycin, and two received streptomycin and PAS with the addition of Terramycin. One patient failed to respond to therapy. He had received streptomycin, Promin, PAS, isoniazid, and viomycin periodically in a program at another hospital.

Ancillary surgical intervention was employed in 3 cases, incision and drainage of fluctuant masses being used in 2 of the cases and excision of residual cervical lymph nodes in 1.

In 12 cases improvement was noted, with diminution in size of the lymph nodes in 11. There was complete resolution in 3 cases.

Discussion

It seems apparent from this study that the colored male in the second and third decade of life is a likely candidate for lymph node tuberculosis. Fourteen per cent of the admissions at this hospital were Negroes.

Concurrent tuberculous disease is to be considered in the diagnostic evaluation of the patient with tuberculosis of the lymph nodes. In 12 cases, tuberculous disease was found involving other tissues. This finding suggests that systemic tuberculosis in some cases becomes clinically manifest as lymph node tuberculosis. Therapy must be based on treatment of the patient as a whole.

The patient who failed to respond to antimicrobial therapy illustrates an important point in medical management; namely, the necessity of continuous antimicrobial therapy and close supervision. This record revealed frequent, short duration periods of therapy with intervals of complete neglect of treatment. The streptomycin or isoniazid were given without PAS except for a one-month period when streptomycin and PAS were given concurrently. Resistant organisms developed.

Incision and drainage was warranted in cases where lymph nodes became fluctuant. It is of interest to note that in 1 case where excision was employed, resolution and diminution in size of the remaining nodes continued with antimicrobial therapy.

Conclusions

1. Tuberculosis of the lymph nodes proved to be a local manifestation of systemic disease in all but 4 of the cases reported in this study. Bed rest and chemotherapy are therefore important in the management of such patients.

2. The good results in this series of cases of lymph node tuberculosis demonstrates that antimicrobial therapy is the treatment of choice, along with ancillary surgical intervention when indicated.

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REFERENCES

1. Aceto, J., Kasuga, K., and Sanderson, S. S.: X-ray therapy of peripheral tuberculous lymphadenitis, Am. Rev. Tuberc. 68:157–164 (Aug.) 1953.
2. Morris, G. J., and Evans, R. G. P.: Treatment of tuberculous cervical adenitis with para-aminosalicylic acid, Lancet 1:1199–1201 (June 2) 1951.
3. Hazlehurst, G. N.: Streptokinase–streptodornase in treatment of suppurative tuberculous adenitis, Surg. Forum (Am. Coll. Surg.), 439–442, 1950.
4. Miller, J. M., Long, P. H., and Stafford, E. S.: Clinical experience with streptokinase and streptodornase in tuberculosis, J.A.M.A. 148:1485–1489 (April 26) 1952.
5. Engel, D.: Treatment of tuberculous lymphadenitis with sodium salicylate (correspondence), Am. Rev. Tuberc. 68:940–941 (Dec.) 1953.
6. Hedberg, G. A.: Changing concepts in treatment of tuberculosis, M. Clin. North America (Mayo Clin. No.) 38:1161–1166 (July) 1954.
7. Gray, J. A. C.: Streptomycin in treatment of tuberculous lymphadenitis, U. S. Armed Forces M. J. 1:476–482 (April) 1950.
8. Cordice, J. W. V., Jr., Hill, L. M., and Wright, L. T.: Use of pyrazinamide (Aldinamide) in treatment of tuberculous lymphadenopathy and draining sinuses; preliminary report, J. Nat. M. A. 45:87–98 (March) 1953.
9. Lester, C. W.: Lymph node tuberculosis and its treatment in accessible nodes (editorial), Am. Rev. Tuberc. 64:691–694 (Dec.) 1951.

Climate and Cutaneous Cancer*

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IN 1934, sometime during our junior year, the members of our class had the privilege of hearing a lecture by Dr. William F. Petersen, then Professor of Pathology at the University of Illinois. Dr. Petersen's basic premise was: "Meteorological environment has a great deal to do with the reaction of the human organism as it finds clinical expression in the inadequacies that we call disease."[1] His extensive observations and theories were published in a work of several volumes entitled *The Patient and the Weather*, which I did not discover until some six years later. While Petersen may have been considered an iconoclast by some, he was most certainly endowed with *prophetic vision*. In the preface to Volume I, he noted that between 1870 and 1934 the entire interest of medicine had been centered on the infectious diseases, thus neglecting the noninfectious ones. He said, "We still stress the infectious diseases in the schoolroom, while the major infections are rapidly disappearing from practice."[2] This was 21 years ago, *before* we had sulfonamides and antibiotics; yet typhoid fever, diphtheria, and other major infections *were* receding. Because, as Petersen says, "disease is fundamentally a functional condition," he recommends, "greater emphasis on the physiological approach, with its more dynamic background and its easy transition in function from the normal, through *excitation*, through *fatigue*, through *dysfunction*, and to *death*."[2] This from a pathologist who deplored "deadhouse pathology" and described prophetically the chain reaction we know now as Selye's adaptation syndrome. Twenty-one years later much more attention *is* being devoted to all of the noninfectious diseases.

Soon after moving to Charlotte, North Carolina, where I entered private practice in 1939, I was impressed by the high incidence of skin cancer in that locality, and by the theory of its etiologic relationship with exposure to sunlight. When I began to investigate the literature on this subject, I discovered Doctor Petersen's material in published form; actually he devoted very little space to the subject of cutaneous cancer because at the time he wrote, the only available statistics were mortality tables, which are not an accurate guide to cancer in the living population. But a series of surveys made by the United States Public Health Service during 1937 to 1944 provided the first extensive data on the incidence of the various types of cancer in our living population.[3-12] Of special significance was the demonstration of the very high incidence of cutaneous cancer in the southern states as compared with that in the other sections studied.

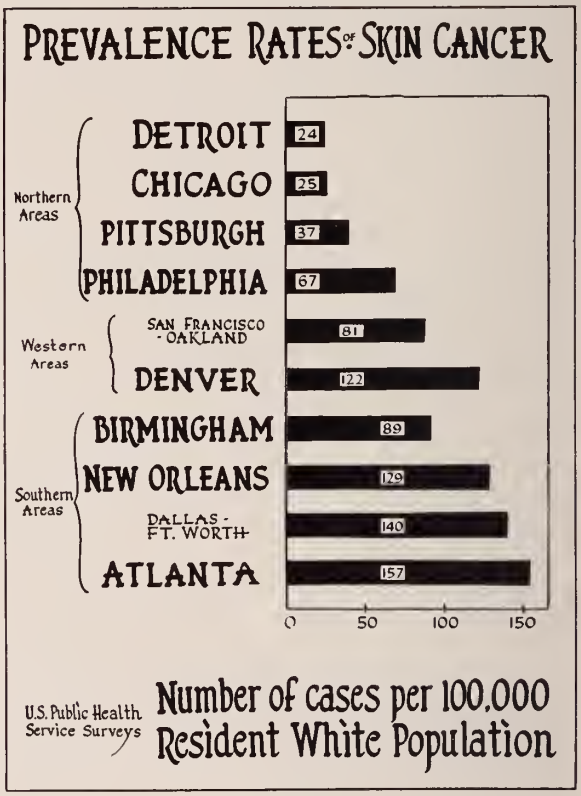


Figure 1.

In the ten metropolitan (and surrounding rural) areas listed in figure 1, an actual census of all patients with a diagnosis of cancer was made.[3] This chart illustrates the prevalence rate of skin cancer per 100,000 *white*

*Presented at the Alumni Day Program, University of Wisconsin Medical School, May 20, 1955.

TABLE 1.—*Cancer of the Skin; Age-Adjusted Incidence Rates per 100,000 Population by Sex, Color, Site and Geographic Region, 1947**

Region	Males		Females	
	Face, head, and neck	Other	Face, head, and neck	Other
	White			
North	26.8	6.6	20.5	4.9
South	120.6	22.7	72.2	15.8
West	80.8	14.8	51.4	12.9
	Nonwhite			
North	2.1	2.2	2.0	2.9
South	2.5	2.9	4.2	4.3

*Adjusted on the total population of continental United States, 1950
From Dorn and Cutler[13]

population (epithelioma being so rare in Negroes). Charlotte, North Carolina, is approximately 300 miles from Atlanta and has similar climatic conditions. Note that the prevalence rate in the Atlanta section is six times as great as that in the Detroit and Chicago areas.

On the basis of recent resurveys of these areas, Dorn and Cutler have demonstrated age-adjusted incidence rates per 100,000 population, broken down according to sex, color, site, and geographic region.[13] The ten areas surveyed are divided into three geographical groups—North, South, and West (See Table 1). In the South there is a consistently higher incidence of skin cancer (even among the Negroes). While epitheliomas occur less frequently in women, those who live in the South have more than three times as many as those in the North. In each of the Southern areas and in Denver the skin is the *most common primary site of all cancer;* in Fort Worth and Dallas over 50 per cent of *all* cancers in white males were primary in the skin. This is in striking contrast to the findings in Chicago, where only 12.5 per cent of all cancers in white males were primary in the skin.

After studying the results of the Public Health Service surveys, one's first thought might be that the incidence of skin cancer parallels the number of hours of sunshine in each geographic section. Through the cooperation of the United States Weather Bureau, data on this and several other climatologic factors were obtained and are shown in Table 2.[14] While the number of hours of sunshine each year is significant, it is not the only factor requiring consideration. For example, Dallas and Fort Worth have 30 per cent more hours of sunshine and 62 per cent more clear days than does Detroit, thus exhibiting a parallel to the prevalence rates of skin cancer in these two areas. On the other hand, when New Orleans is compared with Chicago, we find the hours of sunshine and the number of clear days almost identical; yet there is a significant difference in the incidence of skin cancer. This seeming paradox is resolved when one notes that the average annual temperature is 40 per cent higher in New Orleans than in Chicago; furthermore, when one compares the average temperature for the winter months (December, January, February, and March), he finds that the average for New Orleans is twice that of Chicago. Most likely then, people of New Orleans are exposed to many more hours of sunshine than people of Chicago.

In the Carolinas our white population has a large component of persons of Scottish and Scotch-Irish descent whose ancestors

TABLE 2.—*Climatologic Data, Obtained from Reports of United States Weather Bureaus*

	Per Cent of Possible Hours of Sunshine Per Year	Average Number of Clear Days Per Year	Mean Annual Temperature, F.	Mean Winter Temperature, F.	Mean Annual Solar Radiation*	Prevalence Rate, Skin Cancer (White)
Atlanta	60	132	61.3	46.4	379 Gainesville	157.0
Charlotte	62	132	60.2	44.6		
Dallas—Fort Worth	67	162	65.6	50.0		139.7
New Orleans	58	125	69.4	57.6	319	129.3
Denver	66	147	50.4	36.3	378 Lincoln	121.7
Birmingham	60	141	63.7	49.1		89.1
San Francisco—Oakland	66	161	56.5	52.2	391 Fresno	81.2
Philadelphia	58	114	54.4	35.9	339 Washington, D.C.	66.7
Pittsburgh	49	86	52.6	32.4	278	36.6
Chicago	58	117	49.2	28.9	270	25.4
Detroit	52	100	48.7	28.4		23.8

*Where the local weather bureau station was not equipped to measure solar radiation, the reading in a nearby city is sometimes given, as indicated.

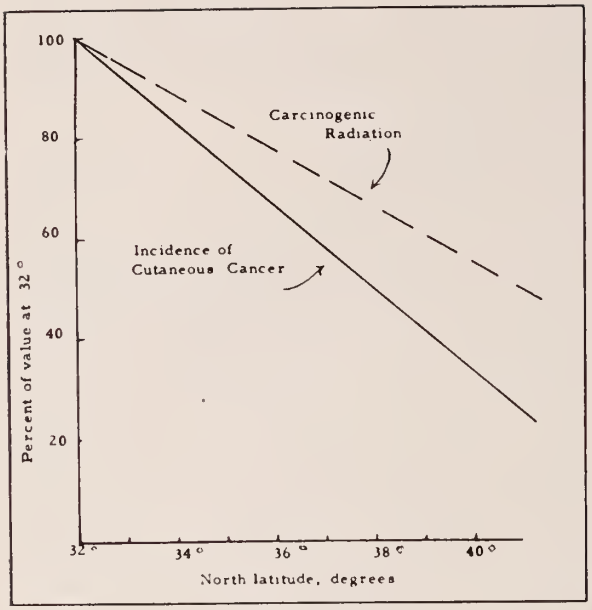


Figure 2.

lived for generations on the British Isles, where they were exposed to very little sunshine. When these people were transplanted to the Carolinas (and the same thing happened to those who migrated to Australia), they took up farming and other occupations which involved frequent and prolonged exposure to sunlight. The descendants of these people still have the fair, ruddy complexion which does not tan and which has little defense against penetration by carcinogenic ultraviolet radiation. The incidence of skin cancer among these people is very high; some produce one or more epitheliomas per year. Occasionally one sees a whole family with epitheliomas.

There is not time here to consider the experimental work and the physics involved in this problem. It is generally agreed that the carcinogenic portion of sunlight is ultraviolet radiation in the range of 3,200 angstrom units and shorter (these amount to about 0.2 per cent of average sunlight). Many laboratory workers *have* succeeded in producing epitheliomas, sarcomas, and other tumors by the experimental radiation of laboratory animals with these wave lengths. If we plot the incidence of cutaneous cancer and the distribution of carcinogenic radiation from sunlight in latitudes north of the equator from 32° to 40°, we have further confirmation of this theory (figure 2).[15] In humans, a susceptible type epidermis repeatedly exposed leads to cancer. Blum states, "Tumor growth is progressively accelerated by regularly repeated doses of ultraviolet radiation, the amount of acceleration being directly proportional to the dose."[16] This also explains the sudden appearance of tumors after a period of apparent latency.

It is not claimed that sunlight is responsible for *all* types of cutaneous cancer; malignant melanomas usually appear on unexposed portions of the skin, for example, and probably have very little if any connection with sunlight. On the other hand, the majority of cancers of the skin are of the basal cell and squamous cell types; and most of these can be attributed with considerable certainty to the action of ultraviolet wave lengths in the range of 3,200 angstrom units.

Briefly, we may sum up the evidence this way:

1. Ninety per cent of cancers of the skin occur on the hands and face.
2. Outdoor workers and others who are exposed to sunlight over a period of years are the most susceptible to this type of cancer.
3. Ultraviolet radiation of wave lengths present in sunlight induces cancer of the skin in mice and rats.
4. Skin cancer (in humans) is much more common in the Southern than in the Northern latitudes.
5. Persons who are relatively immune to sunburn, particularly Negroes, are less susceptible to skin cancer.

Conclusion

After reviewing this material, one can hardly escape a philosophical observation; namely, that great prophets are as rare and perhaps as little heeded in our profession as in other walks of life! I am sure Hippocrates is still in good repute in these hallowed halls; so let me close with this quotation from his "Airs, Waters, Places."

"If it be thought that all of this belongs to meteorology, you will find out on second thought, that the contribution of astronomy* to medicine is not a very small one, but a very great one indeed, for with the seasons men's diseases, like their digestive organs, suffer change."

*Calendar of the Greeks.

403 North Tryon Street.

REFERENCES

1. Petersen, William F.: Patient and Weather, Ann Arbor, Edwards Brothers, Inc., 1935, vol. 1, part 2, p. v (preface).
2. Petersen, William F.: Patient and Weather, Ann Arbor, Edwards Brothers, Inc., 1935, vol. 1, part 1, p. ix (preface).
3. Mountin, J. W., Dorn, H. F., and Boone, B. R.: Incidence of cancer in Atlanta, Ga., and surrounding counties, Pub. Health Rep. 54:1255–1273 (July 14) 1939.
4. Dorn, H. F.: Incidence of cancer in Cook County, Illinois, 1937, Pub. Health Rep. 55:628–650 (April 12) 1940.
5. McDowell, A. J.: Incidence of cancer in Pittsburgh and Allegheny County, Pennsylvania, 1937, Pub. Health Rep. 55:1419–1451 (Aug. 9) 1940.
6. McDowell, A. J.: Incidence of cancer in Detroit and Wayne County, Michigan, 1937, Pub. Health Rep. 56:703–739 (April 4) 1941.
7. McDowell, A. J.: Incidence of cancer in New Orleans, La., 1937, Pub. Health Rep. 56:1141–1170 (May 30) 1941.
8. McDowell, A. J.: Incidence of cancer in Dallas and Fort Worth, Texas, and surrounding counties, 1938, Pub. Health Rep. 57:125–139 (Jan. 23) 1942.
9. Sommers, H. J.: Incidence of cancer in Birmingham and Jefferson County, Alabama, 1938, Pub. Health Rep. 57:377–397 (March 13) 1942.
10. Sommers, H. J.: Incidence of cancer in San Francisco and Alameda counties, California, 1938, Pub. Health Rep. 57:1566–1586 (Oct. 16) 1942.
11. Sommers, H. J.: Incidence of cancer in Philadelphia, Pa., 1938, Pub. Health Rep. 57:1843–1857 (Dec. 4) 1942.
12. Sommers, H. J.: Incidence of cancer in Denver, Colorado, 1939, Pub. Health Rep. 57:1971–1986 (Dec. 25) 1942.
13. Dorn, H. F., and Cutler, S. J.: Morbidity from cancer in United States, Public Health Surveys monograph in press.
14. Elliott, Joseph A., and Welton, David G.: Epithelioma; report on 1,742 treated patients, Arch. Dermat. & Syph. 53:307–322 (April) 1946.
15. Blum, Harold F.: Sunlight as a causal factor in cancer of skin of Man, J. Nat. Cancer Inst. 9:247–258 (Dec.) 1948.
16. Blum, Harold F.: On mechanism of cancer induction by ultraviolet radiation, J. Nat. Cancer Inst. 11:486 (Dec.) 1950.
17. Hippocrates: Airs, Waters, Places, in Petersen: Patient and Weather, vol. 1, part 1 (flyleaf).

PREPARATION OF MANUSCRIPTS FOR THE WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: All correspondence relating to publication of scientific papers should be addressed to the Medical Editor.

Manuscript should be typewritten, double spaced, and the original, not the carbon copy, submitted unrolled. Paper should be 20 pound white, 8½ by 11, providing a 1½-inch margin on the left, an inch on the right, an inch at the bottom, and an inch at the top. The metric system of measurement should be used throughout the paper. Authors should keep a duplicate copy of their manuscripts.

Identification: Name of author and page number should appear at the upper left-hand corner of each page except the first.

Footnotes and references should conform to the style of the *Quarterly Cumulative Index Medicus* published by the American Medical Association, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wis. Med. J. 54:717–719 (Dec.) 1954.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Each illustration, table, etc., should bear the author's name on the back. Photographs should be 3 by 5 glossy prints and clear and distinct. Drawings should be made in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

Comments on Treatment

Editor—HARRY BECKMAN, M. D., Marquette University, Milwaukee

Digitalis in the Shock of Coronary Occlusion

A very interesting report was recently made of the primary treatment with an intravenously administered cardiac glycoside of 4 patients with myocardial infarction, 1 in clinical shock and 3 with shock and pulmonary edema.[1] All 4 patients showed remarkable clinical response with a rise in blood pressure, decrease in pulmonary edema, and dramatic clearing of coma; 3 of the 4 ultimately survived. The authors reemphasized that the shock of myocardial infarction represents true myocardial failure and that the use of digitalis may be highly efficacious. They stressed that in these cases many of the toxic complications associated with the use of digitalis may be avoided by administering only one-fourth to one-half the initial dose that would be given to the average cardiac patient.

It is to be hoped that the experience recorded by these authors will stimulate thorough restudy of the matter. The arguments against digitalis are of course that it may decrease cardiac output in the absence of congestive failure, may rupture the infarct, or may induce or potentiate ventricular tachycardia or fibrillation. I wonder how many readers of these lines are aware that Herrick in his classic article on coronary heart disease written in 1912,[2] actually recommended routine employment of digitalis in myocardial infarction? The entire passage may well be quoted: "If these cases are recognized, the importance of absolute rest in bed for several days is clear. It would also seem to be far wiser to use digitalis, strophanthus or their congeners than to follow the routine practice of giving nitroglycerin or allied drugs. The hope for the damaged myocardium lies in the direction of securing a supply of blood through friendly neighboring vessels so as to restore as far as possible its functional integrity. Digitalis or strophanthus by increasing the force of the heart's beat, would tend to help in this direction more than the nitrites. The prejudice against digitalis in cases in which the myocardium is weak is only partially grounded in fact. Clinical experience shows this remedy of great value in angina, and especially in case of angina with low blood pressure, and these obstructive cases come under this head. The timely use of this remedy may occasionally in such cases save life. Quick results should also be sought by using it hypodermically or intravenously. Other quickly acting heart remedies would also be of service." —HARRY BECKMAN, M. D.

REFERENCES

1. Garlin, R., and Robin, E. D.: Cardiac glycosides in treatment of cardiogenic shock, Brit. M. J. 1:937–939 (April 16) 1955.
2. Herrick, J. B.: Clinical features of sudden obstruction of coronary arteries, J.A.M.A. 59:2015–2020 (Dec. 7) 1912.

TB ASSOCIATION ANNUAL MEETING SET FOR APRIL 19–20

"Old Battle—New Tactics" is the theme of the 48th annual meeting of the Wisconsin Anti-Tuberculosis Association to be held at the Hotel Schroeder, Milwaukee, April 19–20.

Six major areas in tuberculosis control will be highlighted at the meeting with each topic to be introduced by keynote speakers at the morning and luncheon sessions. The topics will be explored in greater detail at round-table discussions scheduled for the afternoons.

Sessions each day will begin at 10 a.m. and continue through the afternoon. There is no registration fee for the meeting nor for any of the sessions.

For further information, write to: Annual Meeting Committee, Wisconsin Anti-Tuberculosis Association, 1700 W. Wells St., Milwaukee 1.

THE MEDICAL FORUM

STATE LAUNCHES NEW OPTICAL AIDS PROGRAM

Study Plans for State Screening Of Foreign Med School Graduates

Madison—Proposals relating to legislative action to enable the State Board of Medical Examiners to establish a program for screening and examining graduates of foreign medical schools received consideration Jan. 10.

The Board enlisted the aid of the State Medical Society's Public Policy Committee in settling on procedure for admittance of the foreign students. This refers to graduates of schools which have not been approved by American medical groups. At present there is no way for graduates to be licensed for practice in the state.

GI's RETURN

Legislation will be essential in creating a program for screening qualified candidates. The proposed method would serve as a preface to the regular examining for licensure.

Each year an average of 120 foreign students apply to the Board for authority to practice in Wisconsin. Also anticipated in the next few years is an influx of American "G. I. Bill students" attending medical schools abroad, who will be subject to similar obstacles now confronting foreign-born applicants.

PROBLEM ELSEWHERE

A recent survey indicated there are 1,734 Americans studying medicine in 22 foreign countries.

Dr. Thomas W. Tormey, Madison, Board secretary, said he had received summaries of programs relating to screening candidates as practiced in Michigan, New York and Pennsylvania. The programs were described as successful in Michigan and Pennsylvania, unsuccessful in New York.

Dr. Tormey said the Board's recommendation is that the state law be changed to allow it discretion in establishing a program whereby ineligible applicants might take additional post-graduate training to qualify for Wisconsin licensure. It also was recommended that as part of this program the Board be permitted to organize a system of testing and evaluating their training and abilities, possibly in conjunction with either the Marquette or Wisconsin medical school, or both.

Richard Hunt, rehabilitatian counsellor for the State Service to the Blind, inspects one of the aptical aids in the partable kits devised far demonstration and test-trial purpases. The kits were endarsed by the Stote Medical Society and will be made avoilable to persons af impaired vision at district offices in Ashland, Eau Claire, Green Bay, Madisan and Milwaukee. (Cliff Hutchinson photo)

NOTE!

Portable kits may be obtained from district offices in Wisconsin as follows:

209 Vaughn Avenue, **Ashland**; 8½ South Farwell, **Eau Claire**; 1442 Main Street, **Green Bay**; 207 North Pinckney, **Madison**, and 2361 North Lake Drive, **Milwaukee**.

Portable Kits to Be Available for Trials

Madison—Launching of a program to acquaint the medical profession and the visually handicapped with recent advances in optical aids was announced recently by the Services to the Blind section of the State Department of Public Welfare's Division on Public Assistance.

In a letter sent this month to Wisconsin doctors of medicine, the Department stated:

3,000 IMPAIRED

"Our interest is strictly educational—not diagnostic or advisory. We define an optical aid as a visual device based on the principle of high magnification which may be used by a person with impaired vision—and there are 3,000 in Wisconsin—for a general sight improvement.

"Portable kits of screened optical aids for demonstration and test-trial purposes are available in district offices in Ashland, Eau Claire, Green Bay, Madison and Milwaukee.

VALUES CITED

"These particular aids are not for sale, but we and other willing sources are interested in seeing to it that no person with limited financial resources needs to be deprived of their usefulness to him.

"We cannot overemphasize the value of such aids, which are endorsed by the State Medical Society, to partially blind persons. They often mean the difference between holding employment or losing it; ability to read or complete dependence upon others for services; full enjoyment of television, movies and spectator sports, or limitation to audio participation.

MORALE BOOSTED

"The constructive impact on the morale is frequently as contributory to rehabilitation as their practical usefulness."

(Continued on page 182)

HAVE YOU WRITTEN YOUR WILL? IS IT FOOLPROOF?

Counsel's Advice Should Be Sought in Will-Making

Madison—You can't take it with you, they say, nor, if your will is faulty, even leave it as you'd like.

A doctor friend told us recently he had drawn up a will in 1941, shortly before entering military service. Now, because of changing tax laws, births in the family, new statutes, a new marital status, change of address and other factors, his will was antiquated.

In other words, if he were to die tomorrow, his bequests would be far out of line with his intent. He plans to revise or rewrite his will in the near future.

MANY DIE INTESTATE

It's hard to believe, but nine of 10 persons die intestate—without a will, or without one a court will approve. The percentage among doctors of medicine is not quite as bad, one out of three leaving this world without a final say-so on disposition of his estate, according

A FORUM FEATURE

to a survey undertaken in Connecticut in 1954.

To have an attorney draw up your will may cost $25 or more, but it's money well spent. However you arrange for this detail, do it with an eye on a few simple rules that keep your will valid. Here are the recommendations:

BE WARY!

1. *See that the document is signed, dated and properly witnessed.* Your attorney, of course, will see to these matters. Wisconsin requires two witnesses, even for *holographic wills,* those in the handwriting of the deceased. *More wills are tossed out of courts for imperfect witnessing than for any other reason.* When picking witnesses, select people younger than yourself—settled members of the community not likely to move away. *Don't pick a beneficiary as a witness;* it probably would disqualify him from receiving the bequest you had in mind. Another don't—*never pick anyone who might conceivably benefit by seeing your will upset.* You and both your witnesses will sign in each other's presence. It's a good idea to have each witness add his address.

LAST WILL AND TESTAMENT

I, FRANK EVERUSH,

of the City of Treetop, County of Sylvan, State of Wisconsin, being of sound mind and memory, do make, publish and declare this my last will and testament, hereby revoking all former wills, bequests and devises by me at any time heretofore made;

FIRST, After the payment of my just debts and funeral expenses I give, devise and bequeath ~~it~~ as follows:

1. I give my home to my wife Caroline.
2. I give the sum of $10,000.00 to be shared equally between my two brothers and my nieces and nephews.
3. One-half of the rest of my estate I give to my wife Caroline.
4. The other one-half I give to my children, Charles and Jane.

The above, of course, is a contrived will to show various faults common in will-making. Dr. Everush was too busy to sit down with an attorney and compose a will, so he had his secretary buy a form at the stationer's. He typed out a few bequests (1, 2, 3, 4), very vaguely, and then had a niece and nephew, both named in the will, as signees—and that's wrong. Many questions were left unanswered: What did he intend giving some persons listed in his will in event some of the others died? Did he intend death taxes be paid out of the estate or by each individual beneficiary? Did he want his executor (his son) to post bond or not? What if the doctor had been killed in an accident and his estate had been sued? Why was no mention made of personal property? This will leaves much to be desired, both for clarity and to conform with law. Without a doubt, it would go to court for final disposition.

2. Name an executor for your estate. It is his duty to settle your debts and execute provisions of your will. Your wife, if she is to receive all your possessions, might be chosen executrix, and thus save your estate the cost of an executor's fees. If you feel the job is too much for her, designate your banker or attorney as a co-executor. Wisely, some persons also pick an alternate executor, to fill in if your first choice dies or moves a far distance away.

LAWSUITS POSSIBLE

3. Don't forget to dispose properly of your personal effects. All too often will-makers forget to mention them. This can invite lawsuits and headaches galore, especially if your belongings include art work, jewelry or the like.

4. Remember to include your life insurance proceeds in any estimate of the size of your taxable estate. Inheritance taxes are a major factor in shaping an estate of any size. Wisconsin will take a cut, of course, and if the estate is large, federal levies will cut off a big chunk.

GIFTS URGED

5. Give some thought while you are still living to allocating portions of your estate to people who are going to inherit them anyway. During your lifetime you may make personal gifts of cash or other property to the extent of $30,000 free of federal gift tax. In addition, you may give up to $3,000 per person each year without cutting into your lifetime exemption. If you are married, you and your wife may pool your exemptions, doubling these amounts. Of course, you must consider the Wisconsin gift tax, too. Wisconsin exemptions are less generous than the federal ones, but rates are lower. In any event, make your gifts before you are a mere hop away from the pearly gates, or the taxmen will view with suspicion your generous acts.

CHECK IT!

6. Be sure to check over your will from time to time, perhaps once every five years or so. Perhaps you'll find that changes are in order, and if so, have your counsel help draft a new will. Another possibility is appending a codicil. This, of course, must be dated, signed and witnessed, too. Never try to change your will by blotting out parts of the original document or inserting additional words.

REMEMBER MRS. M.D.

7. Have your wife make a will at the same time you do. If you've put property in her name, this is particularly vital. Should she die first, you may end up with only one-third of her holdings—if she left no will. Remember, a husband can't claim as much of his wife's estate as she can claim of his.

8. Bear in mind the key factor in any physician's estate-plan is his will. Don't attempt a "home-

(Continued on page 182)

Fight Against Polio Netting Results, But Battle Not Yet Won, NFIP Reports

New York—The year 1955 was a period of problem as well as success in battling polio, the National Foundation for Infantile Paralysis said in its January report.

On the plus side:

10,000,000 children received the Salk vaccine, proven safe, potent and effective.

PRODUCTION STREAMLINED

Vaccine production difficulties early in 1955 were overcome, and the day of universal vaccination now foreseeable.

On the minus side:

Epidemics still not ended; struck heavily in Massachusetts, Wisconsin and Oregon.

The year's toll of 30,000 cases, with many suffering paralytic after-effects.

The Foundation said March of Dimes funds provided vaccine for 7,000,000 youngsters, with an estimated 3,000,000 more receiving shots through other sources.

O'CONNOR COMMENTS

Basil O'Connor, March of Dimes president, said:

"We certainly have learned lessons. We have learned that the American people, by joining together with their scientists in a voluntary partnership, can take a baffling disease and defeat it.

"The defeat of polio has not come, but we know, as we knew when the effectiveness of the Salk vaccine was established, that polio will be beaten, finally and irrevocably.

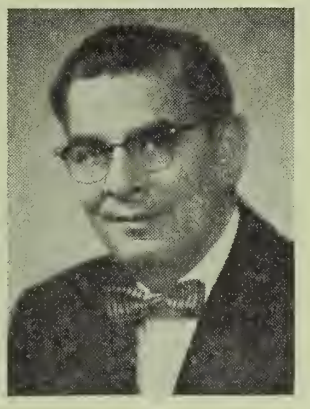
"Every child who receives vaccine brings us closer to that victory. Every iron lung patient who is taught how to breathe without that lung, and who is returned home, represents an advance toward our goal."

"YEAR TO REMEMBER"

Massachusetts reported close to *4,000* cases last year. *In Wisconsin the total was 2,500, four times as many as in 1954.* The Foundation made emergency shipments of 248 iron lungs into the two states.

Last year was a year, the Foundation said, when one vaccine from one manufacturer was found to contain live virus, when an unprecedented reappraisal of safety tests was accomplished, and when apparently serious difficulties in manufacture were met successfully.

A 12-month study of the Salk vaccine ended in news regarded as one of 1955's bright spots, "making it a year to remember," the Foundation added.



Dr. C. E. Koepp

DR. KOEPP NEW AMA ALTERNATE DELEGATE

Madison—Dr. Charles E. Koepp, of Marinette, a past president of the Marinette–Florence County Medical Society, has been named Alternate Delegate to the AMA.

He succeeds Dr. G. E. Forkin, Menasha, whose term expired January 1.

Dr. Koepp served almost five years in the Army Medical Corps during World War II.

He is a member of the State Medical Society's Wisconsin Veterans' Medical Service agency, serves as medical advisor to the Wisconsin Interscholastic Athletic Association, and is a member of the Society's Committee on Veterans' Affairs.

A map showing the location of the S.M.S. building and other health and medical spots in Madison is available. Just drop a request to the S.M.S. and one will be sent to you promptly.

* * *

Remember—You are welcome to visit the new State Medisal Society of Wisconsin building in Madison any time!

Seek New State School Health Consultant

Madison—The State Board of Health is searching for a new state school health consultant to succeed **Mrs. Catherine K. Campbell,** who held the post for 15 years.

Mrs. Campbell resigned to begin work Jan. 16 as assistant professor of health education at Wayne University in Detroit.

Instrumental in organization and development of the Wisconsin Cooperative School Health program, she was a charter member of the State School Health Council. She also served as secretary of the health section of the Wisconsin Education Association, as consultant to the School Health Division of the State Medical Society and on the committee on health of the State Department of Vocational and Adult Education.

Your Family's Happiness and Future Depend on You!

Protect Them With TIME'S Health–Accident Insurance

Time
INSURANCE CO.
Milwaukee, Wisconsin

UW PRECEPTORSHIP PLAN ENTERS 31st YEAR

Medical School and Preceptorial Centers Work Closely

By Dr. ROBERT C. PARKIN

Madison—The preceptorial-type of medical training was historically a very popular teaching method in the days of the American colonies and for some period after the Revolutionary War. Most of the available physicians were preceptor-trained. Prior to that time one can find evidences of this type of training on the continent of Europe.

LIVES TOGETHER

A preceptor may be defined as one who teaches by example. Ideally, the preceptee lives in the house of the preceptorial physician, assisting him in his daily tasks and learning not only about the medical practice but also about the life of a physician.

The University of Wisconsin Medical School established a four-year course in 1925. With rare foresight the first dean, the late **Dr. Charles R. Bardeen,** decided to attempt to capture the good qualities of the preceptorship program as a teaching aid at the state school, the first institution of the modern group of medical colleges to establish a preceptorship program.

SEARCH STARTED

Dr. Bardeen and the late **Dr. Joseph Evans** surveyed the state in an attempt to find typical practitioners who were also good teachers and who were willing to give of their time for teaching purposes without financial remuneration.

It is a real tribute to the doctors of this state that so many volunteered to implement the preceptorial program.

U.W. ONE OF 32

At the present time Wisconsin is one of 32 medical schools which have some form of preceptorship as a part of the curriculum. In addition, this is one of the few schools where the preceptorship is a requirement for graduation, so that each member of the senior class is exposed to preceptorial instruction for one quarter of his senior year. In order to implement this program the senior year in medical school at Wisconsin has been extended from an academic year to a full calendar year.

STATEWIDE COVERAGE

At the present time there are 16 preceptorial centers in Wisconsin. At each center one physician serves as preceptor-in-charge and he is appointed as an extra-mural faculty member of the University of Wisconsin Medical School. The preceptor-in-charge is extended the privilege of appointing other practitioners in the area as associate preceptors to assist him in this instruction.

Only one preceptorship is located in Milwaukee, for the reason that a studied attempt was made to expose the students on preceptorship to medical practice in a semi-rural situation.

PRACTICAL PRACTICE

The senior student on preceptorship is designated as a preceptee. The preceptor-in-charge accepts full responsibility for the student's instruction during one-quarter of his senior year on a rotational basis at each of the various centers. The services of the associate preceptor are made use of in whatever way the preceptor-in-charge designates and, of course, this varies, depending upon the local situation.

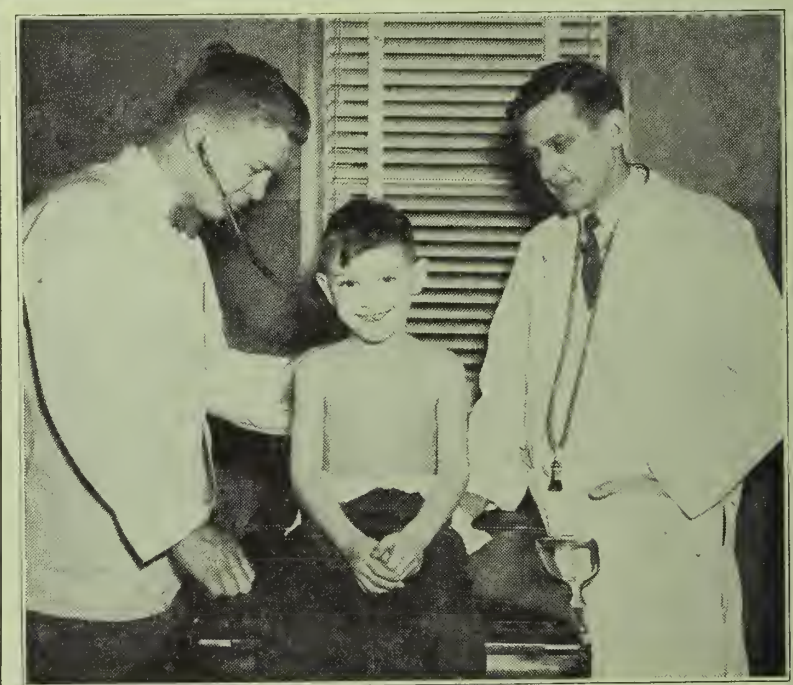
Despite the fact that in some areas the student lives in the local hospital and may perform some duties for the hospital in return for room and board, it is understood that the preceptorial experience is to includee office practice and house calls in addition to hospital practice, however and whenever such is possible.

RECORD MAINTAINED

The student is required to keep a daily log of his experiences during his preceptorship, which he submits to the dean of the medical school upon his return to Madison.

The relationship between the preceptorial centers and the Medical School is maintained by inviting the preceptors and associate preceptors to the medical school on a twice-yearly basis. During the fall semester a two-day scientific program is presented especially

(Continued on page 179)



THE PRECEPTORSHIP PROGRAM IN ACTION—At Westby, Dr. P. T. Bland watches as Student Ben Ruzy (left) checks a youthful patient, who seems happy with the proceedings. Ruzy, a senior medical student at the University of Wisconsin, lives in Madison. The little fellow was not identified.

PRECEPTORS . . .

(Continued from page 178)

for the preceptors by the medical school faculty. At the time of commencement the preceptors again come to Madison for a business meeting with the medical school administration, which includes discussion of problems and policy for the conduct of thte preceptorship. At this time also the preceptors are introduced to the students who will be their preceptees during the coming year and relay whatever instructions are necesary to these students.

FOLLOWUP CONTACT

In addition a faculty member from the medical school visits the preceptor in his home community once yearly for the purpose of discussing problems with respect to the particular preceptorship and afterwards submits a report of his visit to the dean of the medical school.

By these various measures an attempt is made to maintain optimum contact between the medical school and the preceptors and to assist the preceptors to make their preceptorship a fruitful educational experience for the members of the senior class.

WORTHWHILE PLAN

It is believed that the preceptorship offers experiences otherwise impossible of accomplishment to the senior medical student. These include a contact with the practice of acute medicine and surgery that is not generally obtainable at University Hospitals in Madison. Also important is the opportunity to observe the impact which illness causes upon the home and the family. Invaluable also is the observation of the office practice of medicine and the conduct of the economics of medical practice.

AIDS RURAL AREAS

It has long been thought that the preceptorship experience has some influence upon the decision of at least some of the senior students to eventually enter practice in smaller Wisconsin communities. *We believe that the preceptorship adds a fullness to the senior medical student's experience which would otherwise be lacking because it is impossible to obtain in any other situation.*

Listen to the "March of Medicine" on any one of 42 Wisconsin radio stations every week.

In mid-December, a Wisconsin Visiting Committee traveled to Virginia and New York to study operations of health departments in those states. Emphasis was placed on the successful development of county and multi-county local health departments through which the Virginia and New York public health programs are administered. In Richmond, the group also observed the state medical examiner system, under the Virginia board of health, which has been described as one of the most successful operations in the country. Dr. Carl D. Neidhold, of Appleton (left), and Dr. Carl N. Neupert, Madison, State Health Officer for Wisconsin, represented the State Board of Health. They are shown above in the office of Dr. Herman E. Hilleboe, Albany, State Health Commissioner for New York (with bow tie). Second from right is Stephen E. Gavin, Jr., Madison, counsel for the State Medical Society. At the right is Dr. N. A. Hill, Madison, who also represented SMS and will report to its Council in the near future on findings made on the trip. Drs. Neidhold and Neupert will report to the State Board of Health.

TV, RADIO GUIDE AVAILABLE AT SMS

Madison—County medical society officers and others interested in an AMA approved list of guiding principles governing participation in television and radio programs are invited to write for a copy from the State Medical Society, P. O. Box 1109, Madison.

It was felt such a guide of principles might be helpful to local and state societies working with commercial sponsors on local programs.

A-1 P/R Leaflet Still Available

Madison—Copies of the AMA leaflet, To All My Patients, are available in the SMS Public Information office in Madison.

The booklet was prepared for doctors of medicine to distribute to their clients in an effort to foster better MD–patient relationships. Medical care services, fees and insurance are among subjects discussed.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

SHORT TAKES

REMEMBER!
Your Annual
Meeting in
Milwaukee
May 1, 2, 3

From "here and there" in the S.M.S. office:

The new "no-schedule" contract of Wisconsin Physicians' Service has been in operation three months. A special team of department employes is reviewing all but routine claims, which then are presented to the physician members of the Claims Committee. **Memo: Mark for pending a complete review of all claims paid in about 60 days. . . .**

Should we establish an administrative policy concerning claims in controversy with other insurance companies? Sometimes physicians ask that we advise whether the firm has properly handled the claim of a particular client. . . .

Take a memo: What can be done about the misleading and potentially harmful TV programs sponsored by chiropractic groups? Most recent to come to our attention tied in the University of Wisconsin with a Madison chiropractic show. Let's refer this to the *Council on Medical Service* and possibly to the **ad hoc Committee on Limited Licensees. . . .**

Wisconsin's welfare department has distributed to all county agencies, other than Milwaukee, 68 pages of typewritten material intended as a manual to develop uniform practice. Our Society OK'd the manual. **But watch developments in Minnesota where the state specified a "maximum" schedule within which local units must operate.** *Is this a possibility here?*

A reminder: All new delegates, together with the Speaker, Vice Speaker, chairman of reference committees and the secretary, will have a special preliminary session prior to the opening of the House of Delegates' meeting in May. This was planned to provide those new to the House with background information as to how it operates and how they best can follow developments and participate. . . .

The AMA Board of Trustees has appointed a special committee to confer with representatives of pharmaceutical groups re dispensing and clinical pharmacies.

Wausau Loan Firm Pays High Tribute to Doctors

Wausau—The Marathon County Building and Loan Association derived much good will for themselves and for the medical profession when they placed the following statement in an advertisement in the Wausau Record-Herald in January:

"Perhaps you do not realize the vital role that these sincere, ever-ready men (doctors of medicine) play in your life, indeed in the life of this entire community.

"*Your doctor is your friend, your counselor, your health advisor.*

"When you need him, he is available night or day. Tireless, rarely considering his own well-being and happiness, he is constantly on guard to protect you and your family from illness.

"*He gives bountifully of his time without remuneration to public hospitals and clinics.*

"He is our greatest healer, our symbol of security."

The subject was aptly titled "A Tribute to Our Physicians.'"

Dr. Neidhold Presents Bloodletter to S.M.S.

Madison—The State Medical Society's collection of historical medical instruments and mementos was enlarged when **Dr. Carl D. Neidhold**, of Appleton, recently presented a bloodletter, described as a family heirloom.

The donor said the instrument was brought to this country by his grandfather in 1860. It consists of a metal device with a spring which permits a series of blades to shoot out; a case for the device and a glass cup for catching blood.

The letting of blood was started in the stone age as a method of treatment by scarification of the skin with sharp-pointed flints. Venesection was practiced in ancient Greece. History also informs us Johann Gottleib Wolstein fought what he called the **"bloody Moloch,"** saying it took away one of nature's best weapons for fighting disease. Bloodletters of his day (the 1700's), however, kept on bleeding patients white.

Historians said the bloodletting process was *"a species of therapeutic vampirism, which sent unnumbered thousands to premature graves."*

The gift, warmly received by SMS officials, is a reminder to physicians and their families that similar artifacts relating to the practice of medicine are sought, and much appreciated as efforts are being made to build up the collection.

HALO . . .

Another in a series of apt cartoons from a publication entitled *Is Your Halo on Straight* accompanies the caption below. The *Halo* series was published for the Ethics and Professional Conduct Council of the Alumni Association of the School of Medicine of the College of Medical Evangelists by San Lucas Press, Los Angeles.

The Omniscient

Comes in three grades—rare, medium and well done.

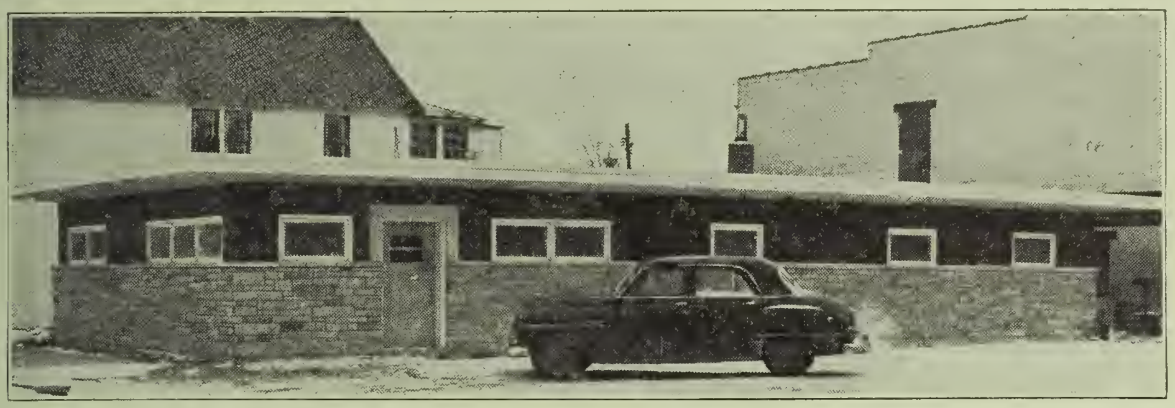
Rare is most common. He dabbles in snap diagnoses and pet therapies. Often conservative. Even consents to consultation if coaxed. Curable.

Medium grade worked his way through rare without getting too scorched. Opinions more positive. Surgery more adventurous. Consults only if sure of confirmation. Amenable to prolonged therapy.

Well-done grade has made it through luck abetted by mum colleagues. His superego is shaped like a dollar sign. Usually does his normals and experimental surgeries at substandard hospital. Has buried his mistakes.

Terminal case.

"Guess I should've used a different book."



Owen Builds Clinic, Gets New Physician

Owen, Wis.—Residents of this Clark County community, without a physician for two years, feel now their effort in building a medical clinic has been rewarded.

With the assistance of the State Medical Society's placement bureau, Dr. Harold M. Braswell, Jr., a native of Bonham, Tex., will come to Owen next June.

WELL-PLANNED

Hoping to attract a doctor, the Owen (pop. 1,034) Development Corporation financed shares of stock in a $22,000 project, an 11-room clinic on the city's business thoroughfare. The Corporation is a non-profit organization of townspeople.

Like a number of other small communities, Owen was without a doctor since **Dr. B. H. Dike** retired after practicing here for 31 years.

His succeessor is Dr. Braswell, 31, who is completing his internship at the University of Chicago Clinics. He served in the U. S. Air Force in 1943–46, and received his degree in medicine from the University of Arkansas in June, 1955. He is married.

AMA PLANS USED

The clinic is a one-story, 36x60 foot structure with a four-foot base wall of Lannon stone and the remainder of the wall finished in redwood. The eves have a three-foot overhang. It is similar to clinics in Marshfield, Spring Valley and Wittenberg. The structure has a large panelled reception room, several examining and x-ray rooms and offices for two doctors. Plans provided through the AMA were utilized.

The city has an ambulance and its fire department personnel is trained and equipped to furnish first aid.

McRoberts Named Head Of State Examiners

Madison—*Dr. Jerry McRoberts*, of Sheboygan, was elected president of the State Board of Medical Examiners at the Jan. 11 meeting of the Wisconsin agency.

Dr. John Schindler, Monroe, was named vice president and Dr. Thomas W. Tormey, Jr., Madison, secretary.

The Board gave written examinations to 36 Wisconsin candidates for medical and surgical licensing and oral tests to 36 from out-of-state. In addition, examinations were conducted for nine physical therapist candidates.

Temporary education permits were granted to six foreign doctors, four from Germany, one from Brazil and another from Japan.

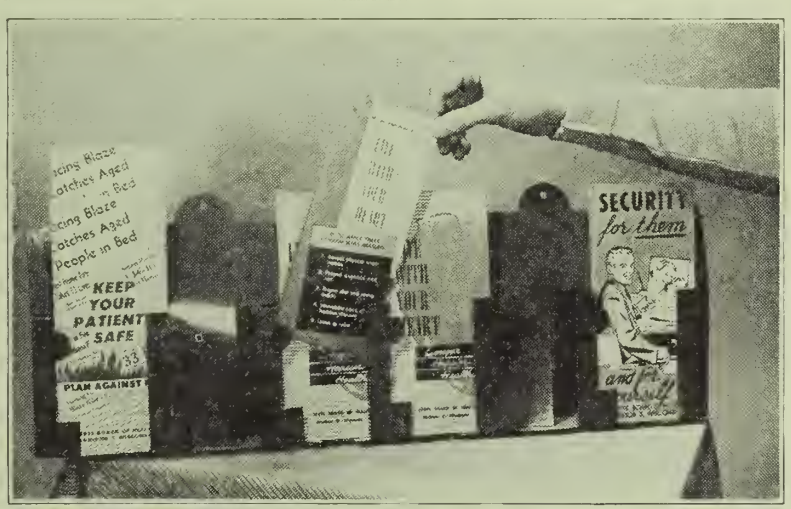
Committee Drafts New Guide for Physicians And Nurses in Industry

Milwaukee—A new approach to industrial health programs for the small plant is being proposed by the Committee on Industrial Health.

In a meeting on January 14, the Committee approved a final draft of the revised guide for physicians and nurses in industry. The guide was first prepared in 1932 when the Society became the first in the nation to issue such a directive. The booklet was revised in 1948.

All editions have been prepared in cooperation with the Industrial Hygiene Division of the State Board of Health.

The guide will be submitted to the Council on Medical Service for approval.



A new pamphlet display stand for doctors' waiting rooms is available without charge from the Wisconsin State Board of Health. It is easily assembled and serves as an effective method for displaying health publications. It can be either hung on the wall or set on a shelf or table. Quantities of pamphlets will be supplied upon request. To obtain a stand and/or a supply of pamphlets, write to Wisconsin State Board of Health, One West Wilson Street, Madison 2, Wisconsin.

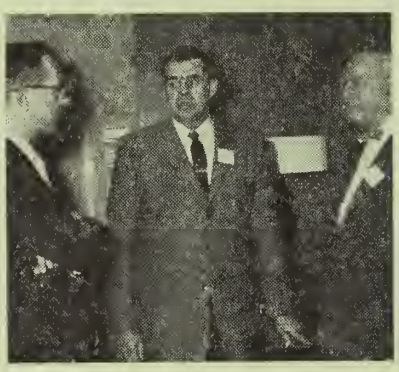
SMS-Clinic Managers' Meeting Rings Bell

Madison—Stress was on current problems and developments when the Wisconsin Clinical Managers' Association met in conference with the State Medical Sociey here Jan. 13–14.

More than 20 managers from throughout Wisconsin attended, and proved enthusiastic and informed participants in the two-day program.

Health care insurance activities, office procedures, medical economics, public relations, field work and other pertinent subjects came under the microscope at the sessions.

As a change of pace, **Ivy Williamson**, athletic director of the University of Wisconsin, spoke on "Badger Sports in 1955 and 1956" and a lively question and answer period brightened his appearance.



Managers taking part in a panel discussion on pertinent problems included **Glenn Anderson**, Eau Claire; **Frank Collins**, Marinette; **Ray Kobow**, Fond du Lac and **William Wilcox**, Black River Falls.

An open meeting of the Society's Claims Committee was another highly-praised event on the program.

Society staff members were busy as speakers, guides through the new SMS "home" and hosts.

HAWAII MED GROUP TO MARK CENTENNIAL

Honolulu, Hawaii—To mark passage of a full century of public service, the Hawaii Medical Association will stage a centennial celebration and scientific congress here April 22–29.

Dr. Clarence E. Fronk, Association president, and Mrs. E. C. Bennett, executive secretary, issued an invitation to mainland physicians to attend.

ON THE S.M.S. CALENDAR . . .

March

2– 3—Tri-State Conference on Health in Colleges, Highland Park, Ill.
3– 4—Commission on Prepaid Plans, SMS
6—Claims Committee, SMS
6– 8—National Rural Health Conference, Portland, Ore.
15—First District meeting, Watertown

April

3—Claims Committee, SMS
8–12—Blue Shield Conference, Hollywood, Fla.
12—School Health Conference, Platteville
19—Sixth and Third District meetings *(sites undetermined)*
22–28—National Medical Education Week

May

1– 3—ANNUAL MEETING, MILWAUKEE

W. C. White (left, assistant secretary of the State Medical Society, visited with clinical managers Wayne Allemang (center), of Mandavi, and Frank Callins, Marinette, during a break in the conference at S.M.S. in January.

WILLS . . .

(Continued from page 176)

made" will or rely on a *form* someone else has used. Your attorney is a specialist in his field, just as you may be in, say, geriatrics. And you know he is no more of an expert in your field than you are in his.

CARELESSNESS HURTS

9. Don't be misled by theorists who hold that a will is unnecessary, who say *"we hold our property in joint tenancy,"* or *"the laws of Wisconsin will take care of the details."* Such arguments, when examined in court, prove inaccurate and trouble-provoking. Deaths, remarriages, changes in tax regulations and a dozen or more things can change the picture overnight.

Sure, it's true that courts have been known to uphold wills written on walls, prescription blanks, pillow cases and the like. **But it's a wise man who is more explicit, who follows the letter of the law. He's making his will foolproof.**

OPTICAL AIDS . . .

(Continued from page 175)

The program was originated by the Division, through its section in Milwaukee, with the assistance of the State Medical Society's Division on Visual and Hearing Defects of the Commission on State Departments.

PLAN OUTLINED

Physicians, and particularly ophthalmologists, were urged to acquaint patients with availability of the test-trial kits at the district offices. Every partially blind person who experiences any improvement through the use of optical aids and who desires to investigate further will be referred to an ophthalmologist, if not already under care.

The department also gave this information relative to referral:

FORMS PROVIDED

"Standard report forms should be provided to ophthalmologists. They should include recommendations concerning possible corrective measures—surgery, treatment, refraction or special aids —and a statement as to whether reading or other use of sight or the use of a magnifier is contra-indicated. If the ophthalmologist states that special aids are not contra-indicated but fails to recommend, he should be contacted and asked to make his recommendations.

RECOMMENDATIONS SOUGHT

"If he recommends a special aid but does not provide a prescription, he should be asked to make his recommendations. If he recommends a special aid but does not provide a prescription, he should be asked whether he can provide or obtain the device or lens suggested. If after consultation, it is determined that the ophthalmologist is not in a position to provide the needed aid, the counselor should feel free to recommend to the ophthalmologist and the client the names of specialists in the field of low-vision aids."

KITS PREPARED

District offices were supplied with the kit containing a selection of simple magnifiers, light control glasses and aids designed specifically for use with low-vision and demonstrated to be useful in many cases at ranges other than conventional test distances.

An Oath

I do hereby swear that I will attend the 1956 Annual Meeting of the State Medical Society of Wisconsin in Milwaukee, May 1–2–3, and that with this oath I pledge immediate action to the following effect:

Mark my calendar to reserve these three days.

Write at once for hotel reservations.

Arrange for another physician to handle my practice during these days.

Begin advising all patients that their welfare is being served by my absence on May 1–3 for improvement of medical knowledge and skill.

I further recognize the avowed objective of the profession for continued improvement of medical knowledge and skill and do hereby pledge to attend all scientific sessions and participate actively in such affairs as constitute an advancement of the Medical Society and the profession of medicine.

Roster of Distinguished Guest Speakers

ANNUAL MEETING, MAY 1-2-3

O. RANDOLPH BATSON, M. D.	Associate Professor of Pediatrics, Vanderbilt University, Nashville, Tennessee
A. E. BRALEY, M. D.	Professor of Ophthalmology, Department of Ophthalmology, State University of Iowa, Iowa City, Iowa
JOSEPH J. BUCKLEY, M. D.	Instructor, Department of Anesthesiology, University of Minnesota Medical School, Minneapolis, Minnesota
CAPTAIN J. G. BULGRIN	U. S. Naval Hospital, Great Lakes, Illinois
FREDERICK COLLER, M. D.	Professor of Surgery, University of Michigan Medical School, Ann Arbor, Michigan
MILTON COPLAN, M. D.	Clinical Professor, Division of Urology, University of Miami School of Medicine, Miami, Florida
STUART C. CULLEN, M. D.	Professor of Anesthesiology, State University of Iowa, University Hospitals, Iowa City, Iowa
JOHN E. FABER, M. D.	Assistant Professor of Obstetrics and Gynecology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota
M. M. FIGLEY, M. D.	Instructor, Department of Radiology, University of Michigan Hospital, Ann Arbor, Michigan
EDWARD A. GALL, M. D.	Director, Department of Pathology, University of Cincinnati College of Medicine, Cincinnati, Ohio
ROBERT R. KIERLAND, M. D.	Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota
VERNON KINROSS-WRIGHT, M. D.	Anderson Department of Psychiatry, Baylor University College of Medicine, Houston, Texas
JOSEPH B. KIRSNER, M. D., Ph. D.	Professor of Medicine, University of Chicago School of Medicine, Chicago, Illinois
WILLIAM B. KOUNTZ, M. D.	Assistant Clinical Professor of Medicine, Washington University, St. Louis, Missouri
JOHN R. LINDSAY, M. D.	Professor of Otolaryngology, University of Chicago School of Medicine, Chicago, Illinois
WILLIAM MENGERT, M. D.	Professor of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago, Illinois
HERBERT RATTNER, M. D.	Professor and Chairman, Department of Dermatology and Syphilology, Northwestern University School of Medicine, Chicago, Illinois
GENE H. STOLLERMAN, M. D.	Assistant Professor of Medicine, Northwestern University School of Medicine, Chicago, Illinois
GRANTLEY W. TAYLOR, M. D.	Assistant Clinical Professor of Surgery, Harvard Medical School, Boston, Massachusetts

Plan To Attend and Hear These Speakers!

Tuesday, May 1

GENERAL PRACTICE DAY

9:00 a.m. **REFRESHER COURSES**

***Geriatrics:**

William B. Kountz, M. D., St. Louis

***Drugs and Malignancy:**

Harry Beckman, M. D., Milwaukee

***Steroids in Dermatology:**

Robert Kierland, M. D., Rochester

***Poliomyelitis:**

O. Randolph Batson, M. D., Vanderbilt University, Nashville
Walter Busby, M. D., Milwaukee
Peter Wisniewski, M. D., Milwaukee
J. C. Peterson, M. D., Milwaukee, Moderator

***Surgery:**

Frederick A. Coller, M. D., Ann Arbor

10:45 a.m. **DRUGS IN RELATION TO GERIATRICS**

William B. Kountz, M. D., St. Louis University

11:15 a.m. **PAPANICOLAOU SMEARS: AN OPPORTUNITY FOR DIAGNOSIS FOR GENERAL PRACTITIONERS**

William D. Stovall, M. D., Madison

2:00 p.m. **WHAT'S NEW AND WHAT'S TRUE IN WHAT'S NEW IN DERMATOLOGY**

Herbert Rattner, M. D., Northwestern University, Chicago

2:30 p.m. **ACUTE HEPATITIS IN INFANCY AND CHILDHOOD**

O. Randolph Batson, M. D., Vanderbilt University, Nashville

3:45 p.m. **SURGERY OF THE GALLBLADDER AND THE BILE DUCTS**

Frederick A. Coller, M. D., Ann Arbor

4:15 p.m. **VISIBLE TUMOR CLINIC**

Robert Kierland, M. D., Mayo Clinic
Herbert Rattner, M. D., Northwestern University, Chicago
Harry R. Foerster, M. D., Milwaukee
David Kersting, M. D., Milwaukee
Sture A. M. Johnson, M. D., Madison, Moderator

6:00 p.m. **WISCONSIN DERMATOLOGIC SOCIETY DINNER** (Members Only)

6:00 p.m. **WISCONSIN ACADEMY OF PEDIATRICS** (Members Only)

Wednesday, May 2

9:00 a.m. **REFRESHER COURSES**

***Obstetrics:**
William F. Mengert, M. D., Chicago

***Surgery in Relation to Cancer:**
Grantley W. Taylor, M. D., Boston

***Radiology:**
M. M. Figley, M. D., Ann Arbor

***Acute Injuries of the Hand:**
Frank D. Bernard, M. D., D. D. S., Madison

***Newer Antibiotics in Pulmonary Infections:**
Elwood Mason, M. D., Milwaukee

***Office Ophthalmology:**
Peter Duehr, M. D., Madison

10:30 a.m. **AIDS IN THE DIAGNOSIS OF LIVER DISEASE**
Edward A. Gall, M. D., University of Cincinnati College of Medicine

11:00 a.m. **OBSTETRICS AND GYNECOLOGY**
John E. Faber, M. D., Rochester

11:30 a.m. **MALIGNANT MELANOMA**
Grantley W. Taylor, M. D., Harvard Medical School, Boston

12:00 Noon **WISCONSIN SOCIETY OF PATHOLOGISTS LUNCHEON** (Members Only)
Edward A. Gall, M. D., University of Cincinnati College of Medicine

1:30 p.m. **SPECIAL SURGICAL PROGRAM** (Open)
Prepared in cooperation with the Wisconsin Surgical Society
(Program to be announced)

1:30 p.m. **SPECIAL PROGRAM ON RADIOLOGY** (Open)
Prepared in cooperation with the Wisconsin Radiological Society
(Program to be announced)

1:30 p.m. **SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY** (Open)
Prepared in cooperation with the Wisconsin Society of Obstetrics and Gynecology
(Program to be announced)

6:00 p.m. **WISCONSIN SURGICAL SOCIETY DINNER** (Members Only)
Grantley W. Taylor, M. D., Harvard Medical School, Boston

6:00 p.m. **WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY DINNER** (Members Only)
John E. Faber, M. D., Rochester, Minnesota

6:00 p.m. **WISCONSIN RADIOLOGICAL SOCIETY DINNER** (Members Only)
Discussant to be announced

Thursday, May 3

9:00 a.m. **REFRESHER COURSES**

***Emergency Treatment of Head Injuries:**
Harry Maxwell, M. D., Milwaukee
Henry Suckle, M. D., Madison
Raymond Quade, M. D., Neenah

***Treatment of Toxic Psychoses:**
Vernon Kinross–Wright, M. D., Baylor University College of Medicine, Houston

***Hematuria:**
Milton Coplan, M. D., University of Miami

***Depressant Drugs:**
Stuart Cullen, M. D., State University of Iowa, Iowa City

***Management of Peptic Ulcer:**
Joseph Kirsner, M. D., Ph. D., Chicago

***The Tonsil and Adenoid Problem:**
John R. Lindsay, M. D., Chicago

10:30 a.m. **RHEUMATIC FEVER**
Gene Stollerman, M. D., Northwestern University, Chicago

11:00 a.m. **URETERAL INJURIES FOLLOWING PELVIC AND COLON SURGERY**
Milton Coplan, M. D., University of Miami

11:30 a.m. **NEWER DRUGS IN THE TREATMENT OF NERVOUS CONDITIONS**
Vernon Kinross–Wright, M. D., Baylor University College of Medicine, Houston

12:00 Noon **WISCONSIN SOCIETY OF INTERNAL MEDICINE LUNCHEON** (Members Only)

12:00 Noon **WISCONSIN UROLOGICAL SOCIETY LUNCHEON** (Members Only)

12:00 Noon **SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY LUNCHEON**
(Followed by Scientific Program)

2:00 p.m. **SPECIAL PROGRAM ON ANESTHESIA** (Open)
Prepared in cooperation with the Wisconsin Society of Anesthesiologists
(Program to be announced)

2:00 p.m. **SPECIAL PROGRAM ON INTERNAL MEDICINE** (Open)
Prepared in cooperation with the Wisconsin Society of Internal Medicine
(Program to be announced)

2:00 p.m. **SPECIAL PROGRAM OF SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY** (Open)
(Program to be announced)

2:00 p.m. **SPECIAL PROGRAM ON UROLOGY** (Open)
Prepared in cooperation with the Wisconsin Urological Society
(Program to be announced)

6:00 p.m. **WISCONSIN SOCIETY OF ANESTHESIOLOGISTS DINNER** (Members Only)

Special Annua

GOLF!

Monday, April 30

The annual tournament of the Wisconsin Medical Golf Association will be held at the North Hills Country Club. Details as to time, dinner and entrance fee can be secured from Mr. Al Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee.

HOUSE OF DELEGATES!

The following schedule of meetings has been planned to provide a minimum amount of conflict for delegates and officers who wish to attend scientific sessions:

Tuesday, May 1:	5:15 p.m.—Buffet Dinner
	6:30 p.m.—First Session
Wednesday, May 2:	8:30 a.m.–12:00 noon—Reference Committees
	7:30 p.m.—Second Session
Thursday, May 3:	8:30 a.m.—Final Session

WOMAN'S AUXILIARY!

Business and social events are scheduled as follows:

Tuesday, May 1:	6:30 p.m.—Board of Directors Dinner
Wednesday, May 2:	9:30 a.m.—Business Session
	1:00 p.m.—Luncheon
Thursday, May 3:	9:30 a.m.—Business Session
	1:00 p.m.—Luncheon and Style Show

NEW DELEGATES MEETING!

Tuesday, May 1

All delegates and alternates serving in the House of Delegates for the first time are invited to a meeting at 4:00 p.m., Parlor A, Hotel Schroeder. The Speaker of the House of Delegates, J. W. Fons, M. D., Milwaukee, will be the host.

Meeting Features

GEMÜTLICHKEIT NIGHT!

Tuesday, May 1

An entertainment innovation which promises a night of fun and excitement for everyone. Physicians and wives are invited at 8:30 p.m. to the Schroeder Hotel Ballroom.

NEW MEMBERS LUNCHEON!

Wednesday, May 2

Each of the nearly 200 new members of the State Medical Society in 1955 will be invited to a special luncheon at 12:00 noon at the Schroeder Hotel. A nationally known figure will discuss medical-legal problems, and officers and staff of the State Medical Society will provide an inside look at socio-economic problems.

SECTION ON MEDICAL HISTORY!

Thursday, May 3

All physicians interested in medical history are invited to a special program at 1:00 p.m. in the Schroeder Hotel. Outstanding speakers and exhibits on the history of medicine will be presented.

ANNUAL DINNER!

Thursday, May 3

The social highlight of the Annual Meeting will be an informal dinner with professional entertainment. "50 Year Club" members will be honored.

Scientific Program

Annual Meeting, State Medical Society of Wisconsin, Milwaukee, May 1–3, 1956

Hour	Tuesday May 1 General Practice Day	Wednesday May 2	Thursday May 3
8:00–9:00 A.M.	REGISTRATION BEGINS OPENING OF EXHIBITS		
9:00–10:45 A.M.	REFRESHER COURSES Geriatrics *William B. Kountz*, M.D Drugs *Harry Beckman*, M.D Dermatology *Robert Kierland*, M.D. Poliomyelitis *O. Randolph Batson*, M.D *Walter Busby*, M.D. *Peter Wisniewski*, M.D. *J. C. Peterson*, M.D. Surgery *Frederick A. Coller*, M.D.	REFRESHER COURSES Obstetrics *William F. Mengert*, M.D. Surgery in Relation to Cancer *Grantley W. Taylor*, M.D. Radiology *M. M. Figley*, M.D. Acute Injuries of the Hand *Frank D. Bernard*, M.D., D.D.S Newer Antibiotics in Pulmonary Infections *Elwood Mason*, M.D. Office Ophthalmology *Peter Duehr*, M.D.	REFRESHER COURSES Head Injuries *Harry Maxwell*, M.D. *Henry Suckle*, M.D. *Raymond Quade*, M.D. Treatment of Toxic Psychoses *Vernon Kinross-Wright*, M.D. Hematuria *Milton Coplan*, M.D. Depressant Drugs *Stuart Cullen*, M.D. The Tonsil & Adenoid Problem *John R. Lindsay*, M.D. Peptic Ulcer *Joseph Kirsner*, M.D., PH.D.
10:00–10:30 A.M.	RECESS TO VIEW EXHIBITS		
10:30–11:00 A.M.	DRUGS IN RELATION TO GERIATRICS *William B. Kountz*, M.D.	AIDS IN THE DIAGNOSIS OF LIVER DISEASE *Edward A. Gall*, M.D.	RHEUMATIC FEVER *Gene Stollerman*, M.D.
11:00–11:30 A.M.		OBSTETRICS AND GYNECOLOGY *John E. Faber*, M.D.	URETERAL INJURIES FOLLOWING PELVIC AND COLON SURGERY *Milton Coplan*, M.D.
11:30–12:00 NOON	PAPANICOLAOU SMEARS: AN OPPORTUNITY FOR DIAGNOSIS FOR GP'S *William D. Stovall*, M.D.	MALIGNANT MELANOMA *Grantley W. Taylor*, M.D.	NEWER DRUGS IN TREATMENT OF NERVOUS CONDITIONS *Vernon Kinross-Wright*, M.D.
12:00–1:30 P.M.	NOON RECESS	WISCONSIN SOCIETY OF PATHOLOGISTS LUNCHEON (Members Only) *Edward A. Gall*, M.D	WISCONSIN SOCIETY OF INTERNAL MEDICINE LUNCHEON (Members Only) WISCONSIN UROLOGICAL SOCIETY LUNCHEON (Members Only) SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY LUNCHEON (Followed by Scientific Program)
1:30–2:00 P.M.		SPECIAL SURGICAL PROGRAM (Open) To be Announced	
2:00–2:30 P.M.	WHAT'S NEW AND WHAT'S TRUE IN WHAT'S NEW IN DERMATOLOGY *Herbert Rattner*, M.D.	SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY (Open) To be Announced Special Program on Radiology (Open) To Be Announced	SPECIAL PROGRAM ON ANESTHESIA (Open) To be Announced
2:30–3:00 P.M.	ACUTE HEPATITIS IN INFANCY AND CHILDHOOD *O. Randolph Batson*, M.D.		SPECIAL PROGRAM ON INTERNAL MEDICINE (Open) To be Announced
3:00–3:45 P.M.	RECESS TO VIEW EXHIBITS		SPECIAL PROGRAM OF SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY (Open) To be Announced
3:45–4:45 P.M.	SURGERY OF THE GALLBLADDER AND THE BILE DUCTS *Frederick A. Coller*, M.D. VISIBLE TUMOR CLINIC *Robert Kierland*, M.D. *Herbert Rattner*, M.D. *Harry R. Foerster*, M.D. *David Kersting*, M.D. *Sture A. M. Johnson*, M.D., MODERATOR		SPECIAL PROGRAM ON UROLOGY (Open) To be Announced
6:00 P.M.	WISCONSIN DERMATOLOGIC SOCIETY DINNER (Members Only) WISCONSIN ACADEMY OF PEDIATRICS (*Members only*)	WISCONSIN SURGICAL SOCIETY DINNER (Members Only) *Grantley W. Taylor*, M.D. WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY DINNER (Members Only) *John E. Faber*, M.D. WISCONSIN RADIOLOGICAL SOCIETY DINNER (Members Only) To be Announced	PRESIDENT'S RECEPTION WISCONSIN SOCIETY OF ANESTHESIOLOGISTS DINNER (Members Only)
EVENING	GEMUTLICHKEIT NIGHT		ANNUAL DINNER (7:00 P.M.)

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: John L. Ford, M. D.

REPORT OF A CASE*

Dr. Richard Jensen: We have an unusual case to present, a case on which Doctor Merline has spent considerable time.

Dr. Gerald Merline: The patient is a female, aged 26, whom I have delivered twice, fortunately with no complications. She has a unilateral (left) swelling, extending from the neck and including the left arm, breast, vulva, and leg.

She was born March 10, 1929. At six weeks of age the parents noted the left side was different from the right. There was no explanation as to the cause. The physician suggested that it would be best to wait a few months to see what would develop. At the age of six years the patient was examined by several physicians, and she stated that no suggestions were made except that one physician thought it was a heart condition and another that it would be a matter for surgery. The patient further states that while she was in grade school, she had a laceration on the lower left leg that failed to heal and emitted only body fluids; it took several stitches to close the wound and many weeks for it to heal.

At the age of 13 she was taken to a Madison hospital and examined. The patient states that no definite diagnosis was given except the supposition that the difference in size of the left side was due to an oversupply of blood and fluids to the left side of the body and that when the menses began, balance might be restored. The physician cautioned against surgery. The patient states that during her teens, hot weather aggravated the condition, especially in the ankle. Her menses do affect the side somewhat and cause more swelling.

I first saw this patient in May, 1952, at which time she was referred to me by another physician. She was pregnant at the time, her last menstrual period having been in November, 1951. Her blood pressure was then 140/86, and she was negative except for a hemihypertrophy of the left side of her body which she said was due to an endocrine disturbance. I delivered her on August 26, 1952; the baby weighed 6¼ pounds, and the patient's weight at the time of delivery was 185 pounds. Her pelvimetry was done at this hospital. The child was entirely normal in all respects and developed normally. At delivery it was thought that some trouble might be anticipated because the left labium was about three times the normal size. A right episiotomy was done, and delivery was without mishap.

The patient again became pregnant in December, 1952. Her weight at that time was 160 pounds, and at delivery it was 185 pounds. There was nothing unusual about the prenatal course except an initial low blood pressure and an intensity of the left-sided swelling, including the labium. She delivered on September 16, 1953. Trouble was again anticipated, but fortunately none developed. The child weighed 7 pounds, 8 ounces. This child, too, was normal in all respects and has been since.

I have followed the patient subsequent to this pregnancy. During this time she complained of a painful nodule on the upper part of the left arm which was thought to be a lipoma. She experienced discomfort for several months, and I finally decided to do a biopsy. An incision was made over the lesion, which occupied the mid-area of the upper arm. The nodule was found and exhibited a meaty appearance. The lesion was attached to a very superficial blood vessel which had dilated to the size of my little finger, and it was closely adherent to the vessel. Because of the proximity of the lesion to the vessel and the swelling in the arm, it was thought best to do a superficial dissection of the lesion because if the continuity of the vessel were interfered with, there might possibly be a further disturbance in the swelling of the arm. The specimen was resected and sent to the pathology laboratory. It was reported to be a benign lymphangioma. Results of an albumin-globulin ratio done at this time were

*From St. Vincent's Hospital, Green Bay

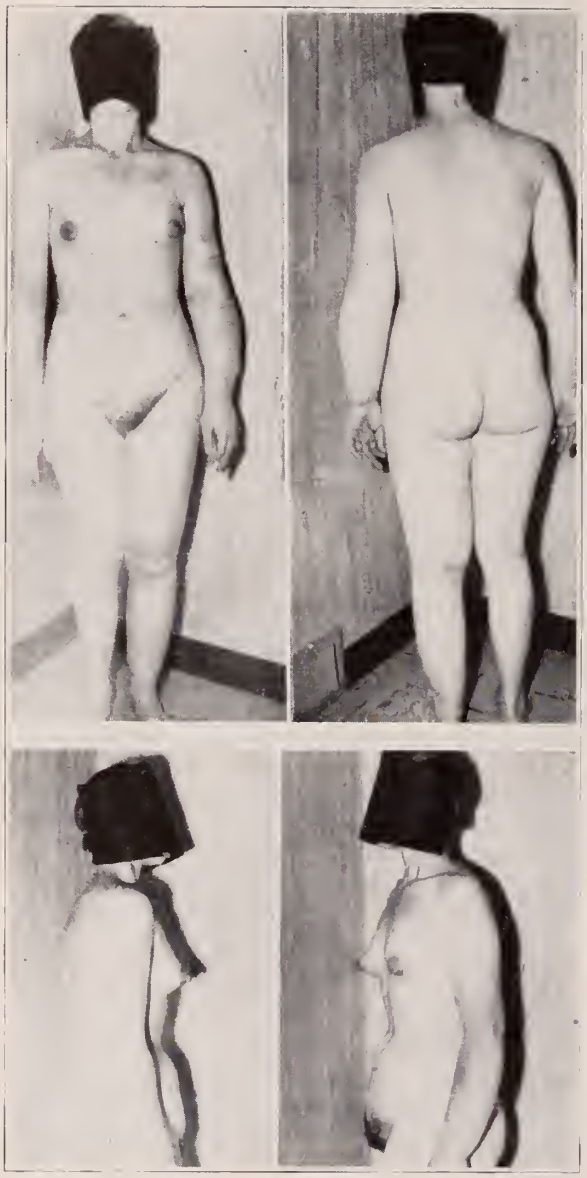


Fig. 1—Photographs of patient during interim between pregnancies.

found to be: total plasma proteins 7.4 gm.; plasma albumin 5.4 gm.; plasma globulin 2.0 gm.; albumin-globulin ratio 2.7 to 1. This patient has several nodules located along the upper arm, in the inguinal area, and in the lower limb.

Figure 1 demonstrates the difference in size of the patient's extremities. The variation in size of the right and left vulva is not as apparent in these photographs as it was toward the termination of pregnancy.

You will note in table 1 that the measurements of the extremities, the oscillometric readings, and the electrophoretic studies demonstrate the physical and chemical differences encountered in this patient.

Dr. M. A. Warpinski. The differential diagnosis in this 26-year-old multiparous female is essentially the diagnosis of chronic lymphedema.

A review of the history reveals the fact that her parents had noticed within a few weeks after birth that inequality existed between the right and left sides, the left side being somewhat larger.

The causes of unilateral hypertrophy, either total or partial, resolve themselves into two general groups, one of which is hemihypertrophy characterized by unilateral skeletal enlargement. Then, there are the mechanical circulatory defects which may be divided into those of inflammatory origin and those of noninflammatory origin. The inflammatory conditions are cellulitis, osteomyelitis, thrombophlebitis, lymphangitis, and elephantiasis due to filaria infection, while the noninflammatory causes are varicose veins, A–V shunts, mechanical obstruction of circulation or lymph channels as a result of trauma or tumor, and chronic lymphedema. The latter may be further subdivided into hereditary or familial lymphedema—the so-called Milroy's disease—and congenital lymphedema.

All of these conditions, with the exception of chronic lymphedema, are readily ruled out in this particular instance by the x-ray studies, physical examination, and history. Of the two subgroups in the category of chronic lymphedema, Milroy's disease is ruled out by the absence of any history of hereditary or familial tendencies, although it must be recalled that the parents did notice a variation in the extremities of the patient in infancy. The only alternative, then, as far as I can see, is to place the case in the category of congenital chronic lymphedema. This classification, in the light of our rather meager knowledge of this condition, is not too satisfactory; and it is quite possible that congenital and hereditary lymphedemas may eventually be classified as one pathological entity.

Dr. Kenneth Mickle: There is very little to add to the discussion of the differential diagnosis just given by Doctor Warpinski.

It might be of interest, however, to present a slightly different classification of this disease group. This classification is taken

TABLE 1.—*Cm. Diameters and Oscillometer Readings of Extremities*

Upper	Diameter Extremities in Cm.				Oscillometer Readings		
	Past Pregnancy Right	Present Pregnancy	Past Pregnancy Left	Present Pregnancy 6 mo.	Normal Index	Right	Left
	Cm.	Cm.	Cm.	Cm.			
Midarm	25.0	25	28	27.5	5–12	10	6–7
Forearm	23.0	26	31.5	31.0	3–10	3	4
Above Wrist	18.0	18	21.0	20.5	1–5	2–3	2
Hand	20.5		20.5		0–1	0–1	0–1
Lower							
Midthigh	46.5		50.0		8–15	3	2.5
Below Knee	32.5	32.5	38.5	38.75	4–10	9	6
Midleg	32.5	33.5	37.5	39.75	3–8	2	4
Above Ankle	19.5	20.0	24.0	27.50	1–5	2	1
Foot	21.0		21.5		0–1		

Blood Serum Electrophoresis Study

	Patient		Normal Range
Globulin	Albumin	59.0%	56.0% ±2.8
	Alpha (I)	6.4%	7.2% ±1.3
	Alpha (II)	12.0%	8.8% ±1.9
	Beta	8.1%	13.3% ±2.5
	Gamma	14.0%	14.7% ±2.6

from a report of patients seen at the Mayo Clinic. Incidentally, as an indication of the rarity of this condition, the writer was able to give only five case histories of patients with this particular type of the disease.

The condition, congenital lymphedema, must first be differentiated from lymphedema praecox, a condition in which edema develops at or soon after adolescence. It is limited to females, involves the lower extremities primarily, and is pathologically distinct from congenital lymphedema. Congenital lymphedema is noticed at birth or in the first few weeks of life.

Dr. John Ford: Before discussing the pathology of this case, it might be well to review the embryology, anatomy, and physiology of the lymphatic system. The embryologic origin is somewhat in doubt, but I believe the consensus is that the endothelium of the lymphatics arises from angioblasts. The lymphatics develop from the veins as five primary lymph sacs. The paired jugular sacs appear first. The iliac buds are also paired. The unpaired retroperitoneal sac develops from the vena cava. The lymphatics then grow peripherally to head, neck, extremities, etc. Then primary and secondary lymph nodes develop.

Anatomically, there are two main collecting channels—the right lymphatic duct and the thoracic duct. The right lymphatic duct is the smaller and is formed by the right jugular, right subclavian, and right bronchomediastinal ducts. The right lymphatic duct empties into the upper portion of the innominate vein. The right jugular drains the right side of the head and neck, the right subclavian drains the right upper extremity, and the right bronchomediastinal drains the right thorax and the upper surface of the liver. The thoracic is the collecting channel for the left jugular, left subclavian, left bronchomediastinal, and lumbar trunks. The lumbar trunks empty into the cisterna chyli and drain the lower extremities and abdomen except for the upper surface of the liver. The cisterna chyli is merely the dilated inferior end of the thoracic duct. The thoracic duct itself empties into the deep cervical veins at the junction of the internal jugular and subclavian veins. There are no lymphatics in the central nervous system, inner ear, or glomeruli of the kidneys.

The lymph channels are closed systems, *i.e.*, they exhibit no direct communication with the interstitial spaces. The tissue lymph apparently enters the lymphatic system by filtration and osmosis. The velocity of lymph flow in the main channeds is said to be 4 mm. per second. The normal lymph trunks are said to be 1 mm. in diameter and have a beaded appearance due to the presence of valves. Lymph itself contains less protein and coagulates more slowly than plasma or blood, and the clot is not as firm. The slower coagulation is apparently due to the absence

of platelets, although lymph does contain calcium, fibrinogen, and prothrombin. The protein content of lymph is roughly proportional to the severity of the lymphedema. The content of protein in lymph from patients with lymphedema is always higher than that in lymph from normal patients. Lymph and tissue fluid are identical in composition. By using radioactive iodine one may determine the rate of absorption of autogenous serum protein by noting the rate of appearance in venous blood. Normal patients have ten times the rate of absorption of lymphedema patients. Patients with severe lymphedema due to metastatic lymph node involvement have even slower rates than those with idiopathic lymphedema. The causes of lymphatic abnormality are obstruction, infection with lymph node involvement, alteration of blood capillary permeability to protein with resultant hypertrophy and dilatation of lymphatics due to constant filling and distention, and congenital malformations of the lymphatics. Continued loss of lymph is attended by inanition, marked weight loss, weakness, thirst, hunger, headache, and syncope. A low fat diet with high protein and high carbohydrate is advantageous. Reinjection of free lymph such as is found in a chylothorax is feasible if there is no contraindication; but severe reactions may follow this procedure, possibly due to some subtle chemical change which occurs in the emulsified fat of the lymph.

In lymphedema a diffuse lymphangiectasis is present in an edematous supporting connective tissue framework. The connective tissue is rich in collagen and poor in elastin. The elastic tissue present is fragmented and shows degenerative change. The subcutaneous fat is relatively small in amount and has a tendency to be replaced by fibrous tissue. The greatest dilatation of the lymphatic spaces is present in the deep subcutaneous tissue near the deep fascia, and becomes less in the more superficial portions of the subcutaneous tissue. The fibrous tissue replacement is, therefore, greater in the deep subcutaneous tissue because lymph stasis itself is greater and because the lymph itself is an excellent culture media for the growth of fibroblasts. In the region of the dilated lymph vessels a perivascular infiltration of lymphocytes is often noted. An occasional lymphocyte is present in the lumina of the dilated lymphatic vessels. The lymph spaces

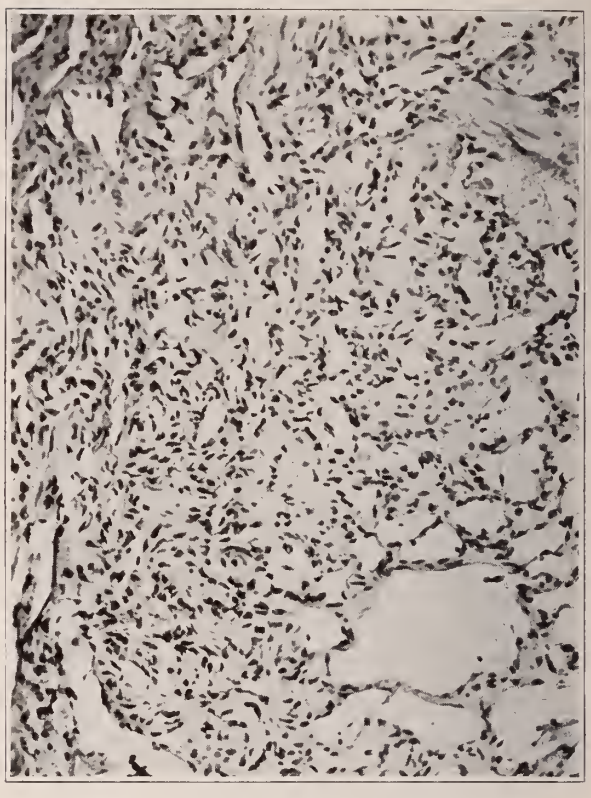


Fig. 2—Low power view of lymphangioma removed from left arm.

of the subcutaneous tissue are lined by a single layer of endothelium with no visible supporting structure. In long-standing cases, fibrotic thickening of the lymphatic wall becomes evident. The interstitial tissue contains pools of lymph which are not contained in a limiting membrane. In addition, in long-standing cases of lymphedema, lymphangiomata develop as in this case (figures 2 and 3), apparently in an attempt to form auxiliary channels. You will note the variability in the size of the innumerable lymphatic spaces, the single layer of endothelial cells with no visible supporting membrane, and the edematous supporting connective tissue framework containing small pools of lymph.

There are various theories concerning the pathogenesis of lymphedema. Briefly these are: congenital malformation of the trophic centers in the spinal cord regulating the growth of cellular tissue, embryonic dyscrasia of the mesoblast, vasomotor nerve disturbance, endocrinopathy, congenital malformation of lymphatic vessels, and venous obstruction.

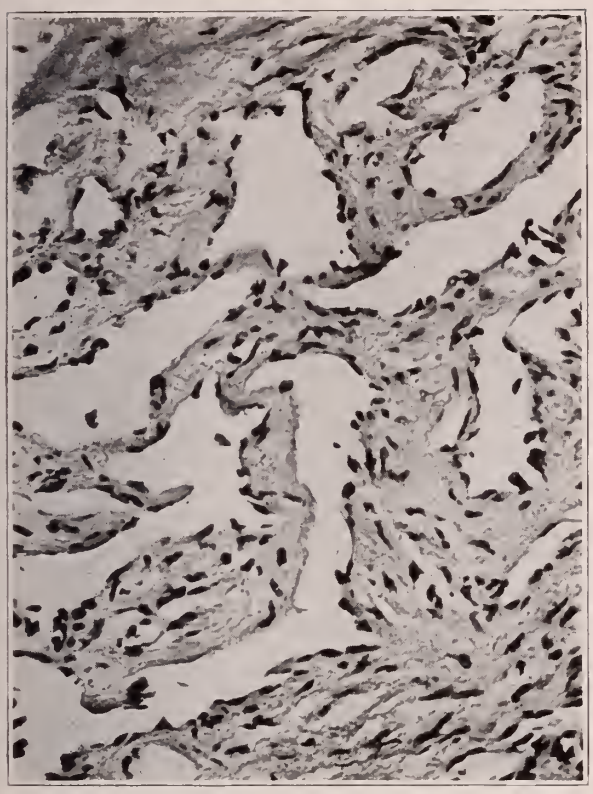


Fig. 3—High power view of lymphangioma removed from left arm.

Dr. George W. Iwen: There are very definite surgical aspects of the entire subject of chronic lymphedema.

I should like to emphasize some of the anatomic peculiarities of the lymphatic drainage system of the extremities. It is upon the basis of these peculiarities that the early concepts of surgical therapy of chronic lymphedema have evolved.

The lymphatic drainage system of the lower extremity can be divided into a superficial and deep system. The superficial system is composed of the intercommunicating, endothelial-lined lymph capillaries located between the skin and the fascia covering the muscle masses. The deep system lies beneath the fascia covering the muscle masses and the traverses in channels that follow in close proximity to the major veins deep in the leg. The important peculiarity is that these two systems do not communicate except in very definite sites; namely, the popliteal fossa and the inguinal area in the lower extremity. There is no communication across the fascia between these areas.

As stated by Doctor Ford, the pathologic changes of chronic lymphedema are found principally in the subcutaneous tissue, corresponding to the superficial lymphatic drainage system. It is here that the dilated telangiectatic lymph channels and lymph lakes surrounded by rather dense fibrous septa have replaced a considerable amount of subcutaneous adipose tissue. As time progresses such an extremity assumes bizarre and gigantic shapes due to the overabundance of this fibrotic lymphedematous tissue.

In the upper extremity the anatomic structure is similar in that there is no communication across the fascia separating the superficial from the deep system except at the antecubital fossa and axilla. Here, too, the overgrowth of the pathologic tissues in the subcutaneous region corresponding to the superficial lymphatic drainage area produces the gross picture of so-called chronic lymphedema.

The etiologic causes of chronic lymphedema have been summarized by previous speakers, and I admit that some of the causes have been surgically induced though, in passing, I suggest that the chronic lymphedema of the arm seen after radical mastectomy is due to either residual metastatic carcinoma in the axillary nodes or to an inflammatory obliteration of the lymph channels immediately surrounding the axillary vessels. I do not believe that one can condemn a meticulously performed radical mastectomy as being productive of chronic lymphedema. The role of irradiation therapy following mastectomy is open to some debate as a consistent cause of lymphedema.

Chronic lymphedema of the lower extremities has been attacked surgically since the 1900's. At this time attempts were made to establish new lymph channels to drain the lymphedematous subcutaneous tissues into more normal tissues towards the central areas of the body. The attempts involved strands of silk; fascia; and, recently, even nylon thread and polyvinyl plastic that were threaded along the subcutaneous tissues of the leg and thigh and embedded in the subcutaneous areas of the lower abdominal wall. It was hoped that new lymph channels would grow along the course of these foreign body threads. Such has not been the case for there is no endothelial lining which accompanies these threads, but rather there are fibrous channels which rapidly contract down.

Doctor Merline: This patient again became pregnant, and approximately at the sixth month of gestation she had several epilepti-

form types of convulsions during which she became unconscious. These attacks were each approximately 5 minutes in duration. Previous to these attacks she had periodic spells during which she complained of "waves" and felt like passing out. At this time in her gestation period she noticed a definite increase in the size of her left extremities and complained of feeling pressure in the left lower abdominal quadrant. The blood pressure and urinalysis had been essentially normal. On admission to the hospital (September 19, 1955) total plasma protein was 7.4 gm.%, plasma albumin 5.4 gm.%, and plasma globulin 2 gm.%. The albumin–globulin ratio was 2.7 to 1. Nothing unusual was found on admission. The patient was hospitalized a few days on sedation and therapy. Her lymphedema decreased, and her convulsions did not recur. On October 20 she was readmitted because of recurrence of the epileptiform convulsions. During the interim since her dismissal from the hospital, she had had two severe attacks, each 5 to 10 minutes in duration. On this admission total plasma protein was 5.95 gm.%, albumin 4.45 gm.%, and globulin 1.5 gm.%. The albumin–globulin ratio was 2.9 to 1. The fibrindex determination was normal. Obstetrical consultation was requested, and a cesarean section was done at the eighth month of gestation. A viable 4 pound, 10 ounce infant was delivered, and at this time (December 1) is normal in all respects. The patient had one convulsion post-cesarean. She developed nuchal muscle spasm which responded to traction and diathermy. A right-sided pleurisy, which complicated the picture, was relieved by antibiotics and heat. The "seizures" were controlled through the use of ammonium chloride and phenobarbital. During this admission skull x-rays were taken and were negative.

It is our opinion that these epileptiform convulsions are the result of increased intracerebral lymphatic pressure secondary to increased peripheral pressure on the lymphatic chain due to the pregnancy.

On December 7 an electroencephalogram was done on this patient. Dr. F. A. Gibbs interpreted the tracings and commented as follows, "Typical psychomotor focus (anterior temporal lobe epilepsy) complicated by 14 and 16 second positive spikes (thalamic and hypothalamic epilepsy). These findings are nonspecific for any particular etiology but most commonly are post-traumatic or postencephalitic. They indicate an irritative reaction to some type of injury which may be traumatic, vascular, or encephalitic. They can be caused by neoplastic disease, but in the present case the loci of disorder are so far apart and there is so little generalized disorder to suggest a large space-occupying lesion that one would have to assume that there are two tumors. There is no diffuse slow activity to suggest a structural degree of brain damage or an acute or progressive pathologic process."

An isolated case of lymphedema such as this is usually considered to be simple congenital lymphedema; however, if the condition is present in several members of a family, then it is designated hereditary or familial lymphedema (Milroy's disease). I believe the line between these so-called two entities is very fine. For a condition such as we have presented here to occur, there must be a start in some generation. Therefore, it is my opinion that a simple congenital lymphedema would be a forerunner of a familial or hereditary lymphedema, if the condition could be followed through succeeding generations.

JOHN HARRIS MEMORIAL LECTURE FUND

A memorial fund has been established in memory of John Harris, M. D., late professor and head of the department of obstetrics and gynecology at the University of Wisconsin. The fund will be used to provide for an annual lecture at the University in the field of obstetrics and gynecology by some nationally known specialist in the field.

Contributions to the fund should be directed to John Z. Bowers, M. D., Dean, University of Wisconsin Medical School.

Civil Defense—Mobile Medical Teams

As It Looks to Your State Board of Health

EXACTLY how many casualties would be caused by the explosion of one thermonuclear weapon in one of our Wisconsin cities is unknown. Undoubtedly there would be thousands. Are we prepared to take care of them? For some time the answer had to be "no"; but that is being changed as more and more mobile medical teams are organized, trained, and equipped.

For purposes of civil defense, Wisconsin is divided into seven mobile battalion areas under the direction of the State Director of Civil Defense. Medical services are supervised by the state health officer as co-director of Health Services in Civil Defense. Each of these areas is assigned the task of recruiting a certain number of mobile medical teams which can be called on to go to the scene of a major disaster within the shortest possible time. To date 47 of these teams have been completed, and 47 others have been organized, at least to the cadre level. An additional 15 still to be organized will bring the total number of mobile medical teams to the 109 recommended as adequate by the Committee on Civil Defense of the State Medical Society.

Efforts to put the recommendation into effect were begun several years ago. They met with considerable initial success in that many teams were organized. However, many fell by the wayside for lack of a definite program. Impetus was given to this project when the State Board of Health authorized the appointment in January, 1955, of an assistant co-director of Health Services in Civil Defense who could devote full time to the recruitment and organization of the mobile medical teams.

As now organized each team is composed of 29 people. The captain is a physician appointed by his county medical society. The deputy officer is also a physician and is appointed by the team captain. In turn they select a business manager and appoint the cadre, consisting of two dentists and two nurses. Other appointments are made by the captain and his business manager and include the following nonprofessional personnel: two medical corpsmen, eight first aiders, four radiological monitors, four stretcher bearers, two clerks, one truck driver, and one carpenter. Supplies and equipment both for training and for actual use are furnished by the state. Most of the supplies are now stored at Camp Williams, ready to be issued as fast as teams are set up.

The need for these mobile medical teams is still present. It is, in fact, growing as other parts of the over-all civil defense plans are put into action. The appointment of the rest of the team captains by the county medical societies, as well as the filling of all positions on all the teams, is now essential. It is imperative that all these persons, above all the captain, be convinced in their own minds that there is a true need for preparedness against the possibility of a catastrophic atom bomb attack. Those of us already in civil defense work believe that here in Wisconsin we must be prepared now.
—THEODORE NOE, *Assistant Co-Director of Health Services in Civil Defense.*

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. . . . THE PRESIDENT'S PAGE . . . .

The Journal of the American Medical Association in its issue of Dec. 24, 1955, carries an informative report on the recommendations of the Committee to Recommend Guides for Grievance or Mediation Committees. The committee was appointed in 1954. This followed the adoption of a resolution several years earlier by the House of Delegates of the A. M. A., which stated in part . . . "that this House of Delegates hereby commends those constituent state associations that have already established grievance committees to hear any complaints of the public and urges that all constituent associations adopt comparable programs . . ."

After a detailed and time-consuming survey, the committee was able to take advantage of existing data and to develop new information through field work. This was used to prepare guides for the organization and operation of grievance committees. The actual details will be left to county and state medical associations to develop for their own individual local requirements.

These guides are now in the process of being printed and distributed for use by medical societies over the entire nation. They will undoubtedly do a great deal to formalize and crystallize the operation of grievance committees in many societies, supplementing those programs already in use and aiding those grievance committees in the formulative stages.

Wisconsin has been progressive through its state and county medical societies in establishing grievance committees, as it has in other important medical organizational matters. The State Medical Society has operated a successful Grievance Committee since 1938. Grievances and complaints of the public—as well as those arising within the profession—have been handled efficiently and in a manner in keeping with the doctrines of good public and professional relations. The Medical Society of Milwaukee County has effectively used its Professional Conduct Committee (now Grievance Committee) to tactfully handle these situations since 1927. At the present time members of the Milwaukee society staff are assigned to interview persons registering legitimate complaints against members of the profession. These reports are investigated by staff members; reviewed at special office staff meetings; and, if necessary, sent to the Grievance Committee for action. The Board of Directors acts on any final recommendations. This system has demonstrated to the public that the profession is willing to listen, is interested, and is ready to police its members when necessary.

Surprising as it may seem to many physicians, these investigative reports reveal that a large percentage of public grievances actually are the result of poor intraprofessional relationships. Unfortunately, more grievances are caused within the profession than originate from the general public.

A word to the wise, as is true with much advice within the classification of public relations, should be sufficient to the members of the profession to help reduce the volume of grievances.

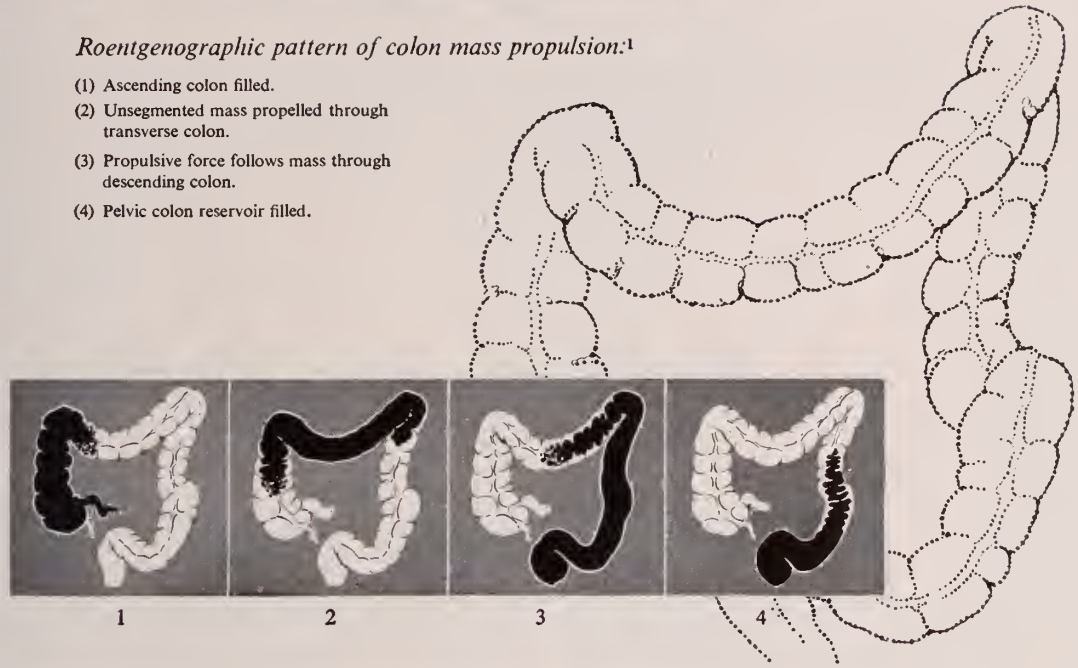
Members of the Wisconsin medical profession, having demonstrated leadership in developing interest in establishing a guide for operating these committees, should be proud of past accomplishments. As president of the State Medical Society, I have many times had an occasion to refer to the work of our Grievance Committee. We should show a continued interest in expanding the philosophy and practical application of medical society grievance committees.

Erwin L. Bernhart M. D.

SMOOTHAGE ACTION IN CONSTIPATION

Roentgenographic pattern of colon mass propulsion:[1]

(1) Ascending colon filled.
(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
(4) Pelvic colon reservoir filled.



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1. Best, C. H., and Taylor, N.B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

SEARLE

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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Scientific Articles

Year after year most of the scientific articles in the Journal come from doctors throughout the state. A few are the presentations of out-of-state speakers at the Annual Meeting. Many are reports of original investigative work from our two medical schools, but more than half come from the practicing physicians of Wisconsin. The editorial board is deeply grateful to these doctors who have devoted their time and effort to the preparation of this material, and for giving us permission to print it.

The editorial board recognizes the dual role of the scientific section of the Journal, and its policies are formulated to reach two objectives. The first of these is to make significant additions to the store of scientific literature. The second is to elevate the practice of medicine by stimulating practicing physicians to clinical and scientific research.

Realizing that the work and study involved in preparation of a report for publication is a great motivating factor, we wish to urge all doctors interested in this kind of medical activity to try their hand at writing articles. Authors usually take a greater interest in scientific medicine than their nonwriting colleagues. The inquiring mind, never satisfied with the inadequacy of present methods, ever seeks better ways through greater knowledge.

On page 173 are suggestions for the preparation of manuscripts. These instructions are printed to answer the many inquiries the editorial office receives for such information, and to facilitate the work of the printer in preparing the material for the presses.

Because the scientific section of the Journal is an important phase of the program of our State Medical Society, we wish to encourage all to yield to the urge to write and to give us the opportunity to publish their work.

Dependent's Day

The dependents of servicemen are getting their day in Congress. Very few will quibble with their right to some special consideration. But there is more than meets the eye in the Defense Department's apparently magnanimous gesture to provide servicemen's dependents with medical and hospital care at government expense. The outward motive is to relieve the military man's worries about his family's health. The Department presumably has doubts about pressing for a pay increase which might or might not be used for health insurance or direct payment of health care costs. Its alternative is a program to pay for illness or injury of dependents, either by herding the dependents into military medical facilities, or paying the costs of a predetermined standard of private health insurance.

Hearings are now under way on what is known as the Vinson Bill, H. R. 7994. In general, it would authorize the provision of medical care and hospitalization by the Federal Government for certain dependents of members of the armed forces. This care would be provided "in military facilities subject to the availability of facilities and . . . capabilities of the medical staff . . ." or through an insurance plan approved by the Secretary of Defense. The bill specifies the type of care to be provided and the categories of dependents included. The Defense Department would be authorized but not required to make "minimal" charges for out-patient care when military installations are involved. Under the insurance plan, the servicemen would pay 30 per cent of the premium.

A great deal of fact finding needs to be done before the care-in-military-installation idea is given preference over the "home-town" care type of program so successful for veterans with service-connected disabilities. Moreover, there is serious question as to the desirability of insuring dependents under government-stipulated contracts through voluntary plans whether by Blue Cross and Blue Shield or private carriers.

Quite aside from such technicalities, this bill bears more than a little watching. No doubt, one of its less publicized intentions is to provide a steady flow of women and children to military medical installations so that doctor-draft physicians can have a "well-rounded" practice. If successful, this bill would undoubtedly result in an expansion of military health facilities and prolong the drafting of physicians for what amounts to private practice in the armed forces. Too many examples of this unhappy result of the doctor draft are already on the records for the thoughtful physician to be fooled by another high-purposed bill, however admirably designed. Perhaps some of the 25 Wisconsin communities without a resident physician will think of this aspect of the Vinson Bill when they encounter difficulty in finding a physician for their home folk, including servicemen's dependents.

One cannot be too sure that the servicemen themselves are so happy with the Vinson proposal. Only recently a small-town practitioner in Wisconsin reported that no less than half a dozen servicemen from his community have, upon leaving for duty, pleaded with him to be sure to take good care of "the wife and kids" if they are ill and to "be sure they don't end up in some army or VA hospital."

True, there is many a slip 'twixt introduction and passage of a bill. The slips may be for better, or they may be for worse. Physicians had best keep their eye on this ball of benefits if for no other reason than to make sure that the "wife and kids" are the real winners on "dependent's day" in the political arena.

Horsepower or Horse Sense

Nearly 400 physicians and industrial health experts recently met in Detroit to take a long and searching look at the most prevalent form of man's inhumanity to man—the automobile accident. If Dr. Elmer Hess, president of the American Medical Association, startled the teen-age set by proposing to ban night driving for anyone under 18 years of age and worried their elders with the suggestion of periodic driver physicals for those over 50, he may also have shocked a good portion of the public to the realization that drastic acts such as these appear to offer one hope of ending the "blood bath" on our highways.

The American people, he said, have demonstrated that traffic statistics are making little impression on their sensibilities. Last Christmas, we killed 609 of our fellow citizens in motor car collisions. "A week later, we celebrated the advent of the New Year by disposing of nearly 400 others in like fashion."

"What sickening madness is this? Has the automobile become our Frankensteinian monster? Have we Americans added to the list of repugnant 'isms' a new and more detestable way of life—moronism? Are we to be governed by horsepower rather than horse sense?"

Without exception, safety experts point to the fact that the socially maladjusted individual is almost chronically involved in accidents, either as cause or victim. Such persons drive as they live—emotionally unstable and mentally confused.

Medicine's responsibility in the automotive age is abundantly clear. Because it, more than any other group, sees the cumulative horror of traffic accidents, it must be among the leaders in changing public attitudes toward driver licensing and suspension. It can learn to prescribe "no driving" for those with many types of physical and mental ailments. It must press for widespread understanding of simple first-aid procedures and the necessity for rapid transportation of the injured to places of adequate treatment. It must cooperate in the gathering of accurate data so that an epidemiologic approach to traffic accidents can be applied in dealing with the host (driver), the agent (automobile), and the environment (highway). The physician's knowledge of anthropology must be utilized to construct machines around the men who use them. Instruments and controls must be treated as extensions of the appendages and the nervous and sensory systems. When physicians treat victims, they have a duty to discover how the accident occurred.

Medicine truly has an important role in proving that injury and death need not be the inescapable price of motion. As Doctor Hess has very appropriately concluded: "We don't need luck; we need horse sense to go with our horsepower."

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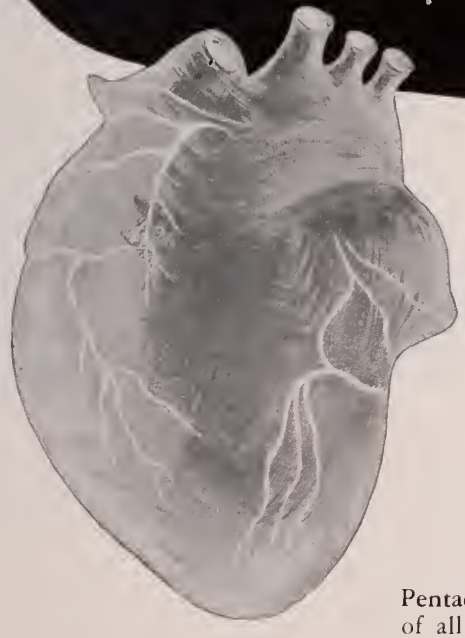

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SAMPLES and LITERATURE ON REQUEST

1. Plotz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)
4. Russek and Assoc., Am. Jl. Med. Sciences (Jan. 1955)
5. Biegeleisen, Clinical Medicine (Oct. 1955)

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Society Proceedings

Brown–Kewaunee–Door

The annual business meeting of the Brown–Kewaunee–Door County Medical Society was held on December 8, 1955, at the Elks Club, Green Bay.

Officers elected for the new year were:

President-Elect—*Dr. G. M. Shinners*, Green Bay
Vice-President—*Dr. J. F. McDermott*, Green Bay
Secretary–Treasurer—*Dr. Frank Urban*, Green Bay
Censor—*Dr. W. A. Killins*, Green Bay
Delegate—*Dr. L. C. Miller*, Green Bay
Alternate—*Dr. J. L. Ford*, Green Bay
Delegate—*Dr. R. M. Waldkirch*, De Pere
Alternate—*Dr. S. L. Griggs*, Green Bay

Dr. Louis A. Milson of Green Bay was installed as president, having been elected president-elect in 1954.

The Emergency Medical Service Committee, under the chairmanship of *Dr. Jack Killins* of Green Bay, presented a report which was given tentative approval. It provides for medical care for nonresidents or persons in the three counties who do not have a private physician. The plan would cover accidents and illnesses of persons who are vacationing in the area and is worked out on the basis of a duty roster of doctors who could be contacted on certain days for this service. Further study will be given to the program by a committee working on details before it is submitted to the society as a whole for final approval.

Crawford

At a recent meeting of the Crawford County Medical Society the following Prairie du Chien physicians were elected as officers for 1956:

President—*Dr. W. S. Cusick*
Secretary–Treasurer—*Dr. H. L. Shapiro*
Delegate—*Dr. T. F. Farrell*
Alternate Delegate—*Dr. O. E. Satter*

Dane

The Dane County Medical Society held its December 13, 1955, meeting at the new office building of the State Medical Society of Wisconsin, Madison. Dr. Thomas H. Alphin, director of the Washington office of the American Medical Association, was the guest speaker and told the group of the activities of the Washington office and its function on government–medical problems. He discussed the presentation of bills into Congress and answered questions from the floor.

At its January 10 meeting in the same location, the society heard an address by Mr. Charles Wilson, superintendent of the State Crime Laboratory. He chose as his subject "Medical-Legal and Related Specialized Technical Aids in the Administration of Justice."

Dodge

The Dodge County Medical Society met at the Waupun Memorial Hospital on November 24, 1955, for election of officers. Physicians who will serve for the new year are:

President—*Dr. R. I. Bender*, Beaver Dam
Secretary–Treasurer—*Dr. M. E. Royce*, Mayville
Delegate—*Dr. L. W. Schrank*, Waupun
Alternate Delegate—*Dr. H. G. Bayley*, Beaver Dam

Grant

Members of the Grant County Medical Society met on December 8 in the Grantland Club Rooms, Lancaster, to elect officers for the new year. New officers are:

President—*Dr. J. W. Conklin*, Platteville
Vice-President—*Dr. Charles Shields*, Fennimore
Secretary–Treasurer—*Dr. H. W. Carey*, Lancaster
Delegate—*Dr. E. C. Howell*, Fennimore
Alternate Delegate—*Dr. M. W. Randall*, Boscobel

Approval was voted to the county health program, which includes administering the third Salk anti-polio vaccine to first and second graders in the county. The serum is also available for shots for children from 1 to 14 years.

Green

At a dinner meeting of the Green County Medical Society on December 6, 1955, at the Monroe Country Club, the following were elected as officers for 1956:

President—*Dr. F. J. Bongiorno*, Albany
Vice-President—*Dr. M. W. Stuessy*, Brodhead
Secretary–Treasurer—*Dr. D. E. Mings*, Monroe
Delegate—*Dr. B. H. Brunkow*, Monroe
Alternate Delegate—*Dr. J. R. Weir*, Monroe

A film on the early diagnosis of lung cancer was shown.

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Green Lake–Waushara

Twelve members of the Green Lake–Waushara County Medical Society met on December 8, 1955, at the Whiting Hotel, Berlin, to hear a talk by *Dr. J. E. Gonce,* professor of pediatrics at the University of Wisconsin Medical School, Madison. Doctor Gonce chose as his subject, "Differential Diagnosis between Congenital Megacolon and Psychogenic Constipation."

Discussion was given to the local immunization program and approval granted to publicity of the fact that the physicians are cooperating in this program.

Jefferson

Twenty members of the Jefferson County Medical Society met at the Meadow Springs Country Club, Jefferson, on December 15, 1955. Officers were elected for the new year, all of them being from Jefferson. They are:

President—*Dr. R. W. Quandt*
Vice-President—*Dr. A. H. Robinson*
Secretary–Treasurer—*Dr. C. E. Quandt*

Kenosha

When the Kenosha County Medical Society met on December 8, 1955, at the Elks Club, Kenosha, election of officers was held. The following Kenosha physicians will serve for the new year:

President—*Dr. J. T. Garren*
President-Elect—*Dr. Leonard Rauen*
Secretary–Treasurer—*Dr. Helen Binnie*
Delegate—*Dr. David Goldstein*
Alternate Delegate—*Dr. H. L. Schwartz*

A report was made by the Industrial Health Committee, which met with the Council from the Manufacturers' Committee for a discussion of common problems. The two committees were scheduled to meet again in January to continue their discussion.

Forty-six members of the society were present.

La Crosse

At the December, 1955, meeting of the La Crosse County Medical Society, the following La Crosse physicians were elected officers for 1956:

President—*Dr. Arnold A. Cook*
Vice-President—*Dr. E. L. Perry*
Secretary–Treasurer—*Dr. James L. Jaeck*
Delegate—*Dr. Robert L. Gilbert*
Alternate—*Dr. J. P. McCann*
Sergeant at Arms—*Dr. Fred Skemp*

Lafayette

The Lafayette County Medical Society met on December 8, 1955, at the Hotel Darlington, Darlington, at which time officers for the year 1956 were elected. They are:

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President—*Dr. L. L. Olson*, Darlington
Vice-President—*Dr. R. E. Oertley*, Darlington
Secretary–Treasurer—*Dr. R. E. Hunter*, Argyle
Delegate—*Dr. L. L. Olson*, Darlington
Alternate Delegate—*Dr. D. J. Garland*, Shullsburg

A report was made by *Dr. D. J. Garland*, medical representative to the county board of health.

Manitowoc

The December 13 meeting of the Manitowoc County Medical Society was devoted to a Christmas party for members and their wives at the Cape Cod Inn, Manitowoc.

On December 29, 1955, the society met at Wellhoefer's Sea Grill, Manitowoc, to observe a movie entitled "Aerosol in Postoperative Pulmonary Congestion." Twenty-one members were present.

Marathon

When the Marathon County Medical Society held its annual dinner meeting at the Wausau Club, Wausau, on December 8, 1955, *Dr. E. B. Brick* of Wausau assumed the office of president, having served as president-elect during the past year.

Officers elected for the new year are:

President-Elect—*Dr. Helen Crawford*, Wausau
Secretary–Treasurer—*Dr. John V. Flannery*, Wausau.

Marinette–Florence

The Marinette–Florence County Medical Society held a joint meeting on November 9, 1955, with the Menominee, Michigan, County Medical Society, at St. Joseph–Lloyd Hospital, Menominee.

Speakers for the meeting were Dr. Sibley W. Hoobler, associate professor of internal medicine at the University of Michigan Medical School, Ann Arbor, and Dr. Paul E. Hodgson, associate professor of surgery at the same school. They spoke on heart disease and high blood pressure.

Milwaukee

The Medical Society of Milwaukee County met on December 6, 1955, at the Elks Club, Milwaukee, for its annual meeting. *Dr. Jerome W. Fons*, new president of the society, presided, and spoke to the group on the need for continued support of Blue Shield and other voluntary prepayment medical care plans as the best way to solve economic problems of medical care.

Election of officers was held, resulting in the following slate for the new year:

President-Elect—*Dr. George S. Kilkenny*
Secretary—*Dr. David W. Ovitt*
Treasurer—*Dr. Edwin C. Welsh.*

Rear Admiral Ellis M. Zacharias (retired), former naval intelligence officer, spoke to the group.

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(1) Poyne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmoel, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Halbrook, W. P.: M. Clin. North America 39:405, 1955.

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He stated that the United States must improve its intelligence service if it is to win the cold war with Russia, and stressed the need for a highly trained staff of psychological warfare experts.

Sir Harold Scott, head of London's Scotland Yard in World War II, spoke on the activities of the police force of London.

On January 12, the society members heard two authorities on hearing problems when they met at dinner at the Athletic Club. Those who attended the annual industrial health clinic that afternoon at the A. O. Smith Corporation were invited to attend the dinner.

Speakers were Dr. Aram Glorig, Los Angeles, California, director of research for the committee on conservation of hearing of the American Academy of Ophthalmology and Otolaryngology, and Dr. Raymond Carhart, Evanston, Illinois, professor of audiology at the Northwestern University School of Speech and professor of otolaryngology at Northwestern.

Mr. Robert B. L. Murphy, legal counsel for the State Medical Society of Wisconsin, Madison, spoke to the group on social security as it applies to physicians.

Oneida–Vilas

The Oneida–Vilas County Medical Society met on December 15, 1955, to elect officers for the year 1956. Rhinelander physicians chosen were:

President—*Dr. Thomas M. Haug*
Vice–President—*Dr. John Magner*
Secretary–Treasurer—*Dr. Marvin Wright*
Delegate—*Dr. Marvin Wright*
Alternate Delegate—*Dr. Irving Schiek, Sr.*

Outagamie

The annual business meeting of the Outagamie County Medical Society was held on November 17, 1955, at Riverview Sanatorium, Kaukauna. Members were guests of *Dr. John Russo.*

A report of the first six months' activities of the Community Blood Center was made by *Dr. H. T. Gross*, medical director; and additional comments were given by Mrs. William Buchanan, chairman of the Board of Directors, and Miss Helen McGrath, executive secretary of the center.

Delegate *Guy W. Carlson* and Alternate Delegate Gross reported on the 1955 State Society House of Delegates meeting, and Doctor Carlson was appointed as the society's representative to the new Charitable, Educational, and Scientific Foundation, Incorporated, of the State Medical Society.

Officers for 1956 were elected as follows:

President—*Dr. Arthur C. Taylor*
Vice–President—*Dr. James W. Laird*
Secretary—*Dr. H. T. Gross*
Delegate—*Dr. Guy W. Carlson*
Alternate Delegate—*Dr. H. T. Gross*

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Surgical Anatomy & Clinical Surgery, Two Weeks, March 5
Surgery of Colon & Rectum, One Week, April 9, May 7
General Surgery, Two Weeks, April 23
Basic Principles in General Surgery, Two Weeks, April 9
Gallbladder Surgery, Ten Hours, April 9
Fractures & Traumatic Surgery, Two Weeks, March 12
Varicose Veins, Ten Hours, March 19, April 30

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, March 12, April 16
Vaginal Approach to Pelvic Surgery, One Week, March 5, April 30

OBSTETRICS—General and Surgical Obstetrics, Two Weeks, March 26, May 7

MEDICINE—Internal Medicine, Two Weeks, May 7
Electrocardiography & Heart Disease, Two-Week Basic Course, March 12
Gastroscopy—Forty-Hour Course, March 19
Dermatology, Two Weeks, May 7

RADIOLOGY—Diagnostic X-Ray, Two Weeks, April 30
Clinical Use of Radioactive Iodine, One Week, April 2
Clinical Uses of Radioisotopes, Two Weeks, May 7

PEDIATRICS—Intensive Review Course, Two Weeks, May 14
Neurological Diseases: Cerebral Palsy, Two Weeks, June 18

UROLOGY—Two-Week Course, April 16
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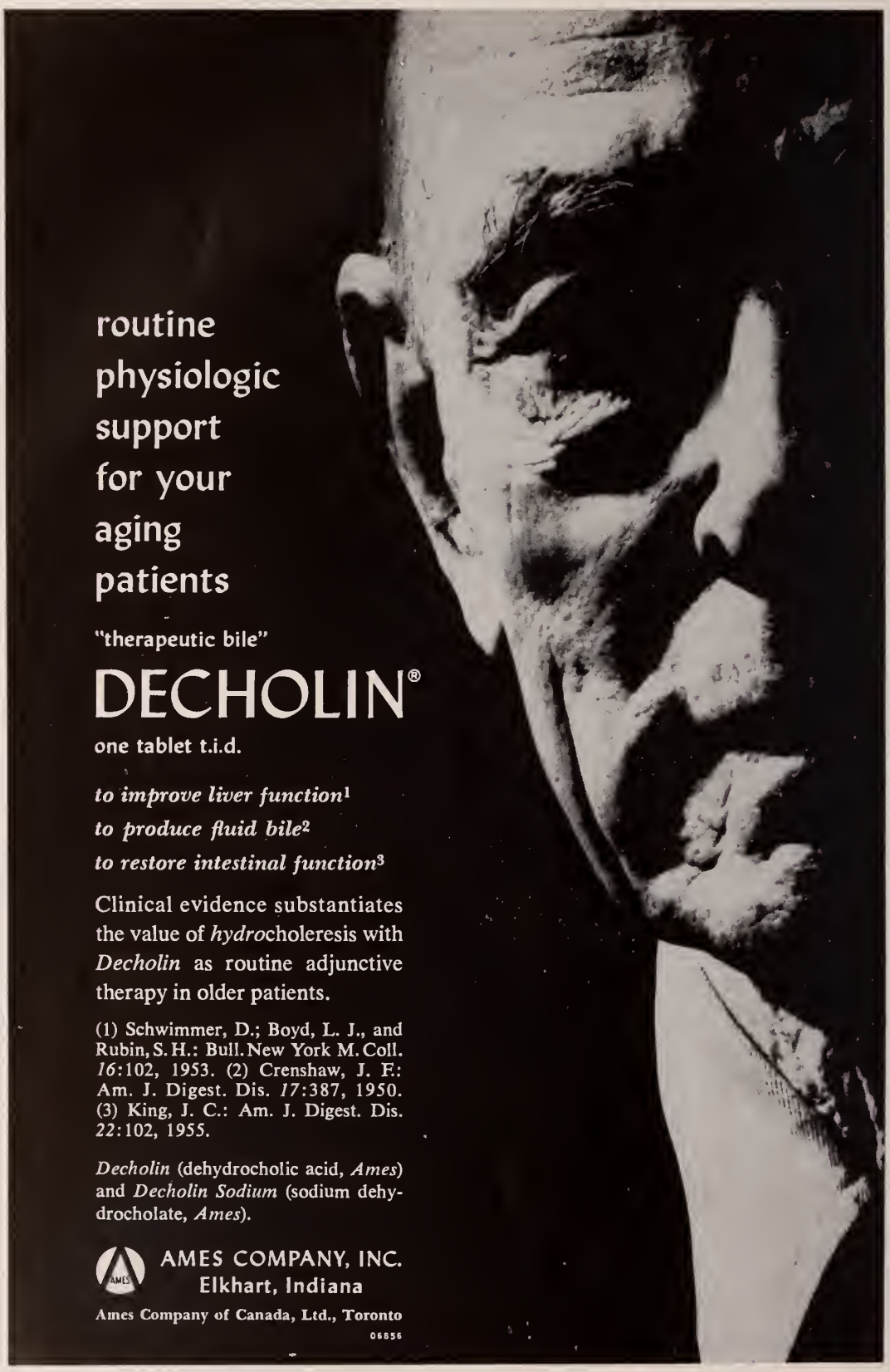
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. 16:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. 17:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. 22:102, 1955.
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All of these new officers are Appleton physicians.

On December 15, 1955, the Society held its annual Christmas meeting with the Woman's Auxiliary. Entertainment was furnished by the Woman's Auxiliary of the Fond du Lac County Medical Society, which staged a comedy play entitled "There Is a Doctor in the House." One hundred and twenty-five members and wives were present at the Elks Club in Appleton on this occasion.

Pierce–St. Croix

The November 22, 1955, meeting of the Pierce-St. Croix County Medical Society was held at Speed's, near River Falls, Wisconsin. Dinner was served at 6:00 p.m.

On January 17, members of the society met at the Steam Boat Inn, Prescott. This was also a 6:00 p.m. dinner meeting.

Polk

Members of the Polk County Medical Society and their wives were guests of *Dr.* and Mrs. *R. G. Arveson* of Frederic on the occasion of the society's annual Christmas meeting, December 15, 1955. Dinner was served at the Methodist Church, and *Dr. L. O. Simenstad* of Osceola showed movies of his recent European trip. A social hour followed at the Arveson residence.

Racine

New officers elected by the Racine County Medical Society recently are:

President—*Dr. L. E. Fazen, Jr.*
President-Elect—*Dr. Robert H. Lehner*
Vice-President—*Dr. Leo M. Lifschutz*
Secretary—*Dr. Frank M. Hilpert*
Treasurer—*Dr. C. W. Christenson*

They assumed office on December 6, 1955.

Richland

When the Richland County Medical Society met on December 1, 1955, in the Richland Hospital Library, Richland Center, *Dr. William Young*, associate professor of surgery, University of Wisconsin Medical School, Madison, was the guest speaker. He spoke on "Cardiovascular Surgery." Eleven members of the society attended.

Richland Center physicians elected as officers for the new year are:

President—*Dr. D. J. Taft*
Vice-President—*Dr. M. J. Epp*
Secretary-Treasurer—*Dr. L. M. Pippin*
Censor—*Dr. Jack Spear*
Delegate—*Dr. D. J. Taft*
Alternate Delegate—*Dr. R. E. Housner*

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On January 17, members of the society attended a postgraduate teaching program held at the American Legion Clubhouse, with dinner served at the Park Hotel, Richland Center.

Rock

On November 22, 1955, members of the Rock County Medical Society met at the Monterey Hotel, Janesville, to hear *Dr. William Boutwell* of Janesville tell of his experiences as a medical missionary in Africa. Doctor Boutwell also showed slides.

Thirty-seven members of the society were present.

Rusk

The Rusk County Medical Society met in January at St. Mary's Hospital, Ladysmith, for the purpose of electing officers for the new year. *Dr. L. M. Lundmark* of Ladysmith was re-elected president, and *Dr. M. L. Whalen* of Bruce was re-elected vice-president. Six members attended the meeting.

Sauk

The Sauk County Medical Society met at the Warren Hotel, Baraboo, on December 13, 1955, at which time Dr. Robert J. Samp, instructor in surgery at the University of Wisconsin Medical School, Madison, was the guest speaker. He spoke on "Forty Ways to Live to be Eighty without Cancer."

Fourteen members of the society were present at the meeting.

Election of officers was held with the following results:

President—*Dr. R. G. Knight,* Reedsburg
President-Elect—*Dr. K. D. Hannan,* Baraboo
Secretary-Treasurer—*Dr. John J. Rouse,* Reedsburg
Censor—*Dr. T. W. Walsh,* Sauk City
Delegate—*Dr. B. E. McGonigle,* Baraboo
Alternate Delegate—*Dr. C. R. Pearson,* Baraboo

On January 10 the society met at the Warren Hotel to hear an address by *Dr. Ralph Campbell,* professor of obstetrics and gynecology at the University of Wisconsin Medical School, Madison. He spoke on "Diagnosis and Treatment of Ovarian Tumors." President Knight announced his committee appointments for the ensuing year.

Walworth

The Walworth County Medical Society met on October 13, 1955, at Traver Hotel, Lake Geneva, to hear a talk by *Dr. W. B. Hildebrand* of Menasha on "Current Changes in the Practice of Medicine." Discussion by the fourteen members present followed.

Fifteen members attended the November 10, 1955, meeting of the society which was held at the Arizona Inn in Delavan. Guest speakers were Mr.

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—Holly, Ray G. Studies an Iron and Cobalt Metabolism, J.A.M.A. 158:1349, Aug. 1955

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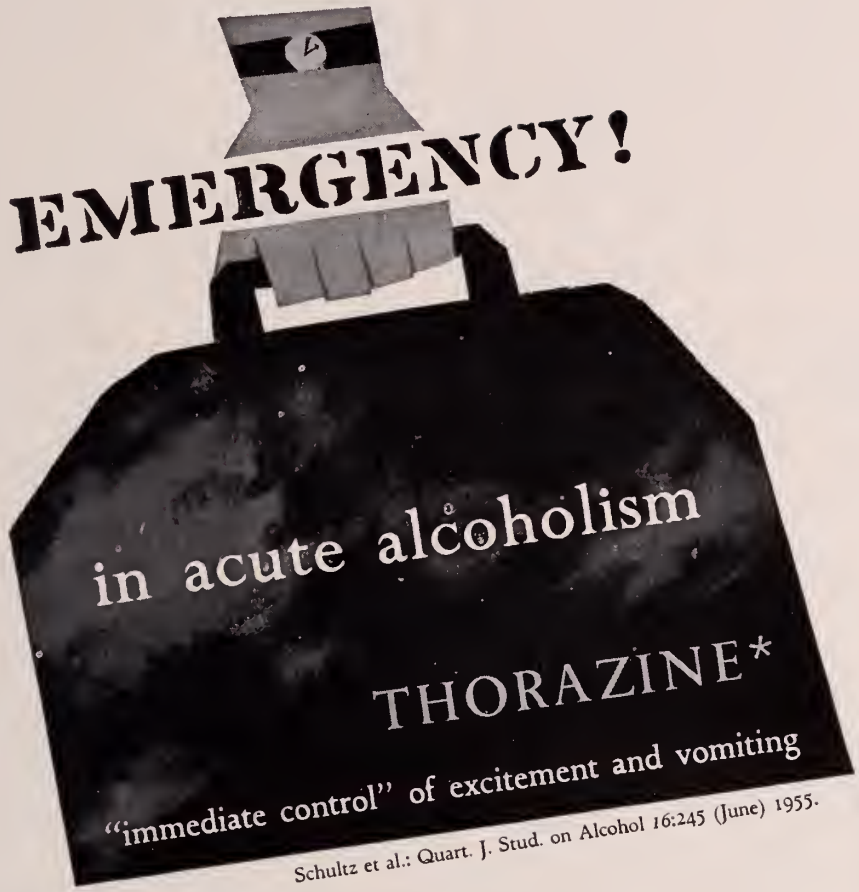

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C. H. Crownhart, secretary of the State Medical Society, who spoke on "Current Legislation Affecting Doctors"; and Mr. Robert B. Murphy, legal counsel of the State Society, who discussed "Loss of Rights of Doctors as a Group."

Miss Jennie Lind of the State Department of Public Welfare was present to explain to the members a study of juvenile delinquency problems and its status in Walworth County. A committee was appointed to study relationship of the county welfare agency to the physicians in the county.

On December 8, 1955, the society met at Lakelawn Lodge in Delavan. *Dr. John Schindler* of the Monroe Clinic, Monroe, spoke on "Functional Diseases in General Practice," and a general discussion followed.

An invitation was extended to all high school faculty members in the county to attend this meeting, and a newspaper notice advised the general public that it was welcome.

Washington–Ozaukee

At a recent meeting of the Washington–Ozaukee County Medical Society the following officers were elected for 1956:

President—*Dr. K. F. Pelant*, Grafton
Vice–President—*Dr. A. T. Grundahl*, West Bend
Secretary–Treasurer—*Dr. J. F. Walsh*, Port Washington
Censor—*Dr. M. E. Monroe*, Hartford
Delegate—*Dr. E. C. Quackenbush*, Hartford
Alternate Delegate—*Dr. P. B. Blanchard*, Cedarburg

Doctor Quackenbush was selected as the society's representative to the Charitable, Educational, and Scientific Foundation, Incorporated, of the State Medical Society.

Waukesha

At the December 7 meeting of the Waukesha County Medical Society, election of officers was held. Those elected for 1956 are:

President—*Dr. A. F. Rogers*, Oconomowoc
Vice–President—*Dr. P. L. Eisele*, Waukesha
Secretary—*Dr. P. M. Wilkinson*, Oconomowoc
Delegate—*Dr. J. A. Bartos*, Waukesha
Alternate Delegate—*Dr. J. V. Bolger, Jr.*, Waukesha

Winnebago

Members of the Winnebago County Medical Society met at the Athearn Hotel, Oshkosh, December 1, 1955, to hear an address by *Dr. J. V. Berger*, Madison. Doctor Berger spoke on "Exophthalmos."

Mr. Frank Thatcher, district sales coordinator of Wisconsin Physicians Service, Appleton, discussed new provisions of the Blue Shield policy.

Wood

When the Wood County Medical Society met on November 10, 1955, at the Hotel Mead, Wisconsin

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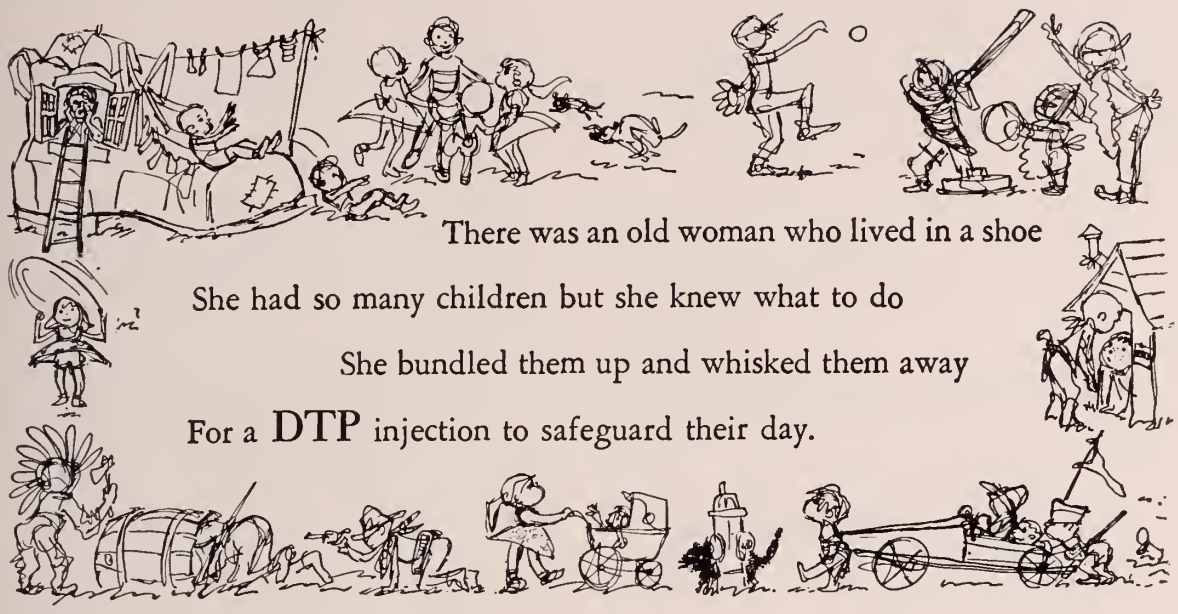

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Rapids, the meeting was devoted to a discussion of current problems and the development of Blue Shield insurance.

Mr. Paul Doege, sales coordinator of the Blue Shield plan, Madison, and Mr. Frank Thatcher, district sales coordinator, Appleton, were the guest speakers.

Twenty-eight members of the society were present.

Interstate Postgraduate Medical Association

The fortieth annual assembly of the Interstate Postgraduate Medical Association was held in Milwaukee on November 15–17, 1955. Wisconsin physicians speaking on the program, and their topics included:

J. S. Hirschboeck, Milwaukee—"Newer Treatments for Pernicious Anemia"

J. A. Schindler, Monroe—"A New Method of Treating Emotionally Induced Illness Adaptable to General Practice"

W. P. Blount, Milwaukee—"Fractures in Children"

F. D. Murphy, Milwaukee—"Evaluation of the Methods of Treatment of Essential Hypertension"

H. H. Reese, Madison—"Present Day Concepts of Muscular Dystrophy and Atrophy"

S. A. M. Johnson, Madison—"The Papulosquamous Skin Conditions, Their Diagnosis and Treatment"

F. J. Hofmeister, Milwaukee—"Problems of Ovarian Tumors"

J. Z. Bowers, Madison—"The Use of Radioactive Iodine in the Treatment of Thyroid Disease"

T. J. Greenwalt, Milwaukee—"Why Not 'Cosmetic' Transfusions?"

Ninth Councilor District Society

A meeting of the Ninth Councilor District Medical Society was held at the Hotel Charles, Marshfield, December 1, 1955, beginning with a social hour at 6:15 p.m.

Guest speakers were *Dr. Armin R. Baier*, instructor in cardiovascular diseases, Marquette University School of Medicine, Milwaukee, who spoke on "Treatment of Cardiac Emergencies," and Dr. P. R. Feingold, associate professor of medicine at Marquette, whose topic was "Pulmonary Fungus Diseases."

About 60 physicians from seven counties in central Wisconsin attended this program, which was sponsored by the Marshfield Clinic.

Milwaukee Academy of Medicine

At the December 20, 1955, meeting of the Milwaukee Academy of Medicine, held at the University Club, Milwaukee, Rene J. Dubos, Ph.D., head of the Department of Bacteriology at Rockefeller Institute of Medical Research, was the guest speaker. He chose as his subject "The Physiological State and Susceptibility to Infection."

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At the January 17 meeting of the Academy at the University Club, *Dr. Einar R. Daniels* was inducted as president for 1956. In addition, the following Milwaukee physicians were elected for the new year:

President-Elect—*Dr. Maurice Hardgrove*
Vice-President—*Dr. Howard J. Lee*
Secretary—*Dr. James E. Conley*
Treasurer—*Dr. C. Morrison Schroeder*
Librarian—*Dr. F. F. Rosenbaum*
Chairman, Membership Committee— *Dr. Donald M. Willson*

Dr. F. Jackson Stoddard was elected to the membership committee and will serve as chairman in 1959.

Honorary memberships were conferred on *Dr. Walter P. Blount*, *Dr. John L. Garvey*, and *Dr. F. W. Madison*, past presidents of the Academy who have held membership for 25 years.

In addition, *Dr. Edith McCann's* membership record of 35 years was noted. She is the first woman to have achieved this record. *Dr. T. S. O'Malley* and *Dr. Herbert C. Dallwig* have also been members for 35 years.

Guest speaker on this occasion was William J. Grede, past president of the National Academy of Medicine, who spoke on "Your Role in Freedom."

Mississippi Valley Medical Society

On November 20, 1955, the state societies of Minnesota and Wisconsin were admitted to membership in the Mississippi Valley Medical Society, increasing its state units to five. Other states included are Illinois, Iowa, and Missouri.

Vice-presidents for the new state members are Dr. Waltman Walters of the Mayo Clinic, Rochester, Minnesota, and *Dr. Arnold S. Jackson*, Jackson Clinic, Madison.

American Academy of Obstetrics and Gynecology

The Fourth Annual Clinical Meeting of the Academy of Obstetrics and Gynecology was held at the Conrad Hilton, Chicago, December 12–14, 1955. It was attended by more than 1,700 members.

Dr. Ralph E. Campbell of Madison, professor of obstetrics and gynecology at the University of Wisconsin Medical School, is president of the Academy for 1956. *Dr. Frederick Hofmeister* of Milwaukee is vice-chairman of District VI.

Wisconsin Academy of General Practice

Rock County Chapter

Dr. Milton J. Donkle, Janesville, was elected president of the Rock County Academy of General Practice at its annual dinner meeting December 14, 1955, at the Beloit Country Club, Beloit.

Others elected were *Dr. W. J. Mauermann*, Beloit, vice-president; *Dr. Esther Rau*, Janesville, secretary-treasurer; *Drs. Richard Thayer* and *D. M. Clark*, both of Beloit, *Dr. M. D. Davis*, Milton, *Dr. Thorn Vogel*, Milton Junction, and *Dr. E. R. McNair*, Orfordville, delegates to the state convention.

The physicians adopted a constitution and by-laws for their organization.

Southwest Wisconsin Chapter

Physicians from five southwest Wisconsin counties met on December 6, 1955, at the new Memorial Hospital in Lancaster for their regular meeting of the recently organized chapter of the Wisconsin Academy of General Practice. Physicians from Dubuque were invited to this session.

Speakers were *Dr. Charles W. Crumpton* and *Dr. E. C. Albright* of the University of Wisconsin Medical School, Madison. Doctor Crumpton discussed "New Advances in Coronary Disease," and Doctor Albright spoke on "Radioactivity in Medicine."

The southwest chapter is composed of general practitioners in Iowa, Lafayette, Crawford, Richland, and Grant counties. *Dr. Norbert McGreane* of Darlington is president.

Tri-County Chapter

Congressman Glenn Davis was the principal speaker at the Tri-Country Chapter of the Wisconsin Academy of General Practice meeting held in Oconomowoc on November 23, 1955.

Dr. J. R. Howlett of Hartland is president, and *Dr. T. H. Nammacher* of Oconomowoc is secretary of the group.

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News Items and Personals

Physicians Attend Postgraduate Courses

Drs. John Martin and *Glenn Smiley* of Delavan, and *George Truex*, Darien, have recently completed a course in surgical anatomy at Cook County Hospital in Chicago. *Dr. R. S. Galgano*, Delavan, completed a course in surgical technique.

Doctor Poser Marks 61st Year as Columbus Physician

Dr. E. M. Poser, Columbus, recently celebrated his 61st year as a physician in the Columbus area. *Drs. John* and *Rolf Poser*, sons of Dr. E. M. Poser, have taken over most of the practice and operate the Poser Clinic; however, the elder physician still accompanies his sons on house and hospital calls and goes to the clinic almost daily.

New London Hospital Names Staff Officers

Dr. W. H. Towne, Hortonville, was named chief of staff of the New London Community Hospital recently. Other officers elected at the annual staff meeting were *Drs. R. K. Irvine*, Manawa, vice-president, and *G. M. LaCroix*, Shiocton, secretary–treasurer.

Doctor Tenney Speaks to P.T.A.

Dr. H. Kent Tenney, Madison pediatrician, was the guest speaker at a recent Berlin High School P.T.A. meeting. He spoke on the "Emotional Problems of Children."

Doctor Epstein Named Honorary Member of French Allergy Society

Dr. Stephan Epstein, Marshfield, was recently elected an honorary member of the French Allergy Society—the Société Francaise d'Allergie. Doctor Epstein is a dermatologist at the Marshfield Clinic.

Dr. C. W. Schmidt Moves to Kansas

Dr. C. W. Schmidt, who for the past two years has been in general practice in Watertown, moved to Kansas City, Kansas, on January 1. He plans to take a residency at the University of Kansas Medical School in the specialty of obstetrics and gynecology.

Rice Lake Hospital Staff Named

Dr. C. F. Cronk, Cameron, was recently elected chief of staff of the Lakeside Methodist Hospital at Rice Lake. Vice chief of staff will be *Dr. A. G. Johnson*, Rice Lake, and secretary, *Dr. D. F. Hammond*, Barron.

Dr. A. H. Hohf Moves to Champaign, Illinois

Dr. A. H. Hohf and his family recently moved from Milltown to Champaign, Illinois.

He had been in general practice in Milltown since 1946. He will now be associated in general practice in Champaign with a former university classmate.

Doctor Ruehlman Leaves Monroe

After more than 25 years of practice in Monroe, *Dr. D. D. Ruehlman* has moved to Kenosha, where he will specialize in gastroenterology and proctology.

Doctor Ruehlman plans to continue his duties as Wisconsin department surgeon of the Veterans of Foreign Wars, a post which he has held since 1949.

Dr. H. M. Coon Speaks at Hospital Dedication Program

Dr. H. M. Coon, Madison, was one of the principal speakers at the recent dedication of the Spooner Community Hospital.

Doctor Coon, who is superintendent of the University Hospitals, spoke on "The Role of the Rural Hospital in the Wisconsin State Health Picture."

Doctor German Appointed to Hospital Staff

Dr. J. D. German, Clintonville, was recently appointed senior surgeon and chief of surgery at Man Memorial Hospital, Man, West Virginia. Prior to this appointment, Doctor German was in general practice at Clintonville.

Dr. M. J. Watunya Named Public Health Officer

Dr. M. J. Watunya, La Crosse, has been appointed local officer for the U. S. Public Health Service.

The main mission of the U. S. Public Health Service is out-patient treatment of service personnel on the Mississippi River, including coast guardsmen, members of the U. S. Army Corps of engineers, seamen, and their dependents.

Doctor Welbourne Named President of Wisconsin Division, American Cancer Society

Dr. R. P. Welbourne of Watertown was elected president of the Wisconsin Division of the American Cancer Society at the annual meeting held recently in Madison.

He has served on the division's board of directors and its executive committee and is chairman of its medical and scientific committee.

Dr. S. T. Sandell Speaks at Superior

Dr. S. T. Sandell, Hawthorne, superintendent and medical director of the Middle River Sanatorium, spoke to the Exchange Club in Superior recently. He discussed incidents of tuberculosis control in Douglas County.

The program was held in the interest of the Douglas County Tuberculosis and Health Association, sponsors of the Christmas Seal program.

Physicians Participate in University of Wisconsin Postgraduate Course

Participating physicians on a panel of the University of Wisconsin postgraduate course on heart disease held December 8 were *Dr. M. J. Musser,* Madison, who discussed emotional problems connected with high blood pressure; *Dr. C. W. Crumpton,* Madison, who spoke of the pharmacological approach to hypertension; *Dr. Herman Tuchman,* Madison, and *Dr. E. S. Gordon,* Madison.

Dr. W. J. Schutz Joins Lancaster Clinic

Dr. Weston J. Schutz, who has practiced medicine in Shawano for the past nine years, recently joined the Grant County Clinic in Lancaster. Doctor Schutz received his medical degree from Rush Medical College and served his internship at St. Mary's Hospital, Madison.

Dr. R. C. Frank Appointed to Cancer Committee

Dr. R. C. Frank of Eau Claire has been appointed to succeed *Dr. Lucille Radke* on the Committee on Cancer of the State Medical Society. Doctor Radke recently left the state. The appointment automatically makes Doctor Frank a member of the board of directors of the Wisconsin Cancer Society.

Dr. E. D. Schwade Speaks to P.T.A.

The Menomonee Falls P.T.A. and the Health Council of Menomonee Falls heard an address by *Dr. E. D. Schwade* of Milwaukee on November 15. He spoke on mental health.

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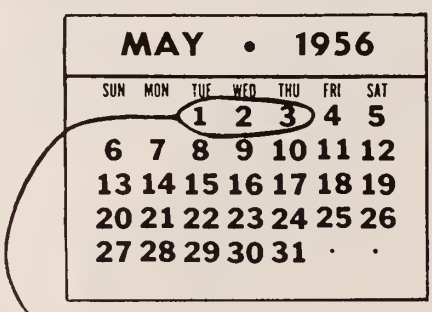

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Dr. N. L. Low Joins University of Utah Staff

Dr. N. L. Low, Racine, was recently appointed associate research professor in pediatrics at the college of medicine of the University of Utah in Salt Lake City. He began his duties January 1.

Staff Officers Named at Fond du Lac Hospital

On January 5, the new staff officers of the St. Agnes Hospital, Fond du Lac, were installed. *Dr. J. S. Huebner*, who is affiliated with the Wiley–Smith Clinic in Fond du Lac, was named chief of staff and *Dr. N. O. Becker*, secretary. *Dr. L. J. Keenan* was elected to the executive committee for a three-year term.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Healy Locates in Madison

Dr. J. R. Healy has recently become associated with *Dr. G. C. Hank* in the practice of obstetrics and gynecology in Madison.

Doctor Healy is a graduate of Jefferson Medical College of Philadelphia, and interned at the Naval Hospital in Boston. He served in the Navy from 1950 to 1952 and later took a fellowship at the Mayo Foundation in obstetrics and gynecology.

Dr. Kurt Wiener Has New Associate

Dr. Kurt Wiener of Milwaukee recently announced the association of Dr. Roger Laubenheimer with him in the practice of dermatology.

Doctor Laubenheimer is a graduate of the University of Wisconsin Medical School, served his internship in Detroit, and after two years of military service, had two years of dermatology residency at the University Hospital in Michigan.

Doctor Bartsch Opens Office in Madison

Dr. H. L. Bartsch has recently entered the practice of urology in Madison. A former resident of Madison, he has for the past eight years been in practice in South Bend, Indiana. He is a member of the American Urological Association, fellow of the American College of Surgeons, and a diplomate of the American Board of Urology.

Physicians Participate in Postgraduate Clinic at Milwaukee County Hospital

Speakers for the first of a series of clinics held on December 10 at the Milwaukee County Hospital auditorium in Milwaukee included: *Dr. Erwin Schmidt*, professor and head of the department of surgery, University of Wisconsin Medical School; *Dr. F. D. Murphy*, professor and head of the department of medicine at Marquette University School of Medicine; *Dr. William Engstrom*, Marquette

University associate professor of medicine; *Dr. George Hullmuth*, director of the cardiovascular section at Marquette; and *Dr. E. G. Olmstead*, assistant medical director of Milwaukee County Hospital.

These clinics are being held the second Saturday of each month.

Staff Officials Named at Madison General Hospital

At the December 27 meeting of staff doctors of the Madison General Hospital, Madison, *Dr. C. O. Vingom*, Madison, was re-elected chief of staff.

Other officers named were *Dr. D. M. Britton*, vice-president; *Dr. N. M. Clausen*, secretary–treasurer; and *Dr. T. Nereim*, representative to the Board of Trustees of the Dane County Medical Society.

Department heads named were: *Dr. Samuel Harper*, surgery; *Dr. Robert Becker*, medicine; *Dr. T. Nereim*, general practice; and *Dr. William Luetke*, obstetrics and gynecology.

Milwaukee Doctor Addresses Honolulu Group

Dr. S. E. Kohn, Milwaukee, spoke on January 26 to the Honolulu Pediatric Society. He chose as his topic, "Diagnostic Criteria for Gastrointestinal Surgery in Infants and Children."

Doctor Kohn is assistant clinical professor of pediatrics at Marquette University School of Medicine, attending physician at Milwaukee Children's Hospital, and director of pediatrics at Mt. Sinai Hospital, Milwaukee.

Dr. M. M. Bortin Certified by Internal Medicine Board

It was announced as of December 2, 1955, that *Dr. M. M. Bortin*, Milwaukee internist, was certified by the American Board of Internal Medicine. Doctor Bortin has been engaged in the practice of internal medicine in Milwaukee for the past five years.

Milwaukee Physician Fellow of American Academy of Obstetrics and Gynecology

Dr. R. T. Flynn, Jr., Milwaukee, was inducted as a fellow of the American Academy of Obstetrics and Gynecology at its fourth annual meeting on December 12–14. The group met at the Conrad Hilton Hotel in Chicago.

Dr. David L. Dean Joins Clinic

Dr. David L. Dean recently joined the Dean Clinic in Madison. He is a graduate of the University of Wisconsin Medical School, served a rotating internship at Cincinnati General Hospital in Cincinnati, and did postgraduate work in general surgery for four years at the Mayo Clinic. Doctor Dean also served with the armed forces for two years.

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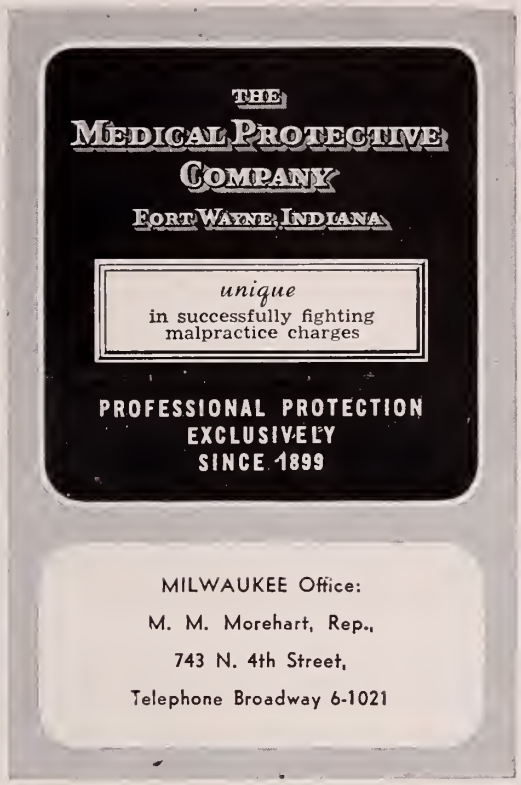
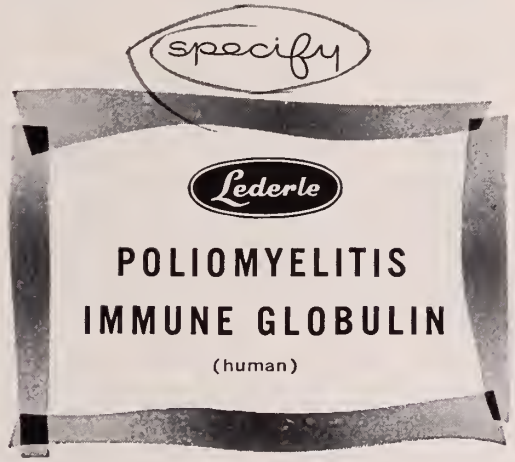
Van B. Philpot, Jr., 1300 University Avenue, Madison.

David L. Dean, 822 Prospect Place, Madison.

A. C. Costello, 324 East Wisconsin Avenue, Milwaukee.

** Military Service.





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R. A. Hanson,** San Antonio, Texas, to 3535th Hospital, Mather AFB, Sacramento, California.

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Shimpei Sakaguchi, Oceanside, California, to 5703 Parapet Street, Long Beach, California.

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** Military Service.

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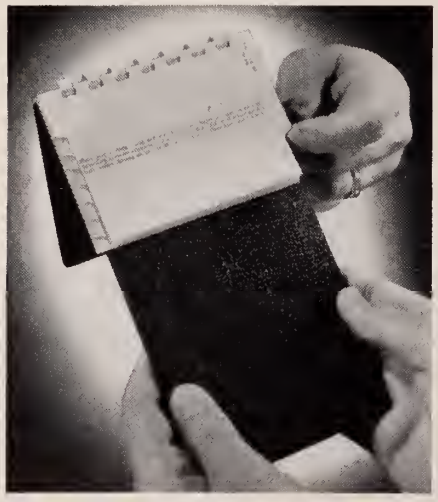

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OBITUARIES

A. L. TATUM, M. D.

Dr. Arthur Lawrie Tatum, emeritus professor of pharmacology at the University of Wisconsin and a member of its faculty since 1928, died on November 11, 1955, at the age of 71 years.

Born in Wall Lake, Iowa, in 1884, he was graduated from Penn College, Oskaloosa, Iowa. For the next two years he served a fellowship in chemistry at the University of Iowa, where he earned his master's degree.

From 1907 to 1910 he was instructor in chemistry at the University of Colorado. In 1913 he received his Ph.D. degree from the University of Chicago and the following year was graduated in medicine from Rush Medical College.

He later was instructor in physiology at the University of Pennsylvania and then professor of physiology at the University of South Dakota. In 1918 he joined the faculty of the University of Chicago as assistant professor of pharmacology.

Doctor Tatum came to the University of Wisconsin in 1928 as a professor, and the following year he assumed chairmanship of the department of pharmacology, retiring in 1954. While at the University, he dedicated himself to the establishment of sound scientific principles in relation to drug action, always with the idea of practical application. His researches led to the publication of some 175 scientific articles. He studied the acute toxic convulsions produced by overdosage of cocaine and demonstrated that picrotoxin, a powerful stimulant of the nervous system, was the antidote for barbiturate overdosage. Studies on acute intoxication with barbiturates led to the investigation of changes in the central nervous system produced by the continued administration of several narcotic drugs, and his observations resulted in the establishment of the physiological basis of addiction and the ultimate realization that the addict is a sick man. In later years Doctor Tatum became vitally interested in the chemotherapy of malaria and especially in the fundamental mechanisms involved in the immune responses to the organisms producing the disease.

In 1942 the University of Toronto presented him with the Charles Mickle Fellowship as "The member of the medical profession who has done most during the preceding ten years to advance sound knowledge of a practical kind in medical art or science."

The degree of Doctor Honoris Causa from San Marcos University, Lima, Peru, was bestowed upon him in 1948.

For many years Doctor Tatum contributed to the "Comments on Treatment" page of *The Wisconsin Medical Journal,* and he had served as a member of the Advertising Committee for the Journal.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, as well as many scientific organizations in the fields of physiology and pharmacology.

Surviving him are his widow; two sons, Dr. Edward Tatum of Stanford University, and Dr. Howard Tatum of the University of Louisiana at New Orleans; a daughter, Mrs. Fred Rasmussen of Santa Monica, California; a sister, Mrs Irwin Heald of West Branch, Iowa; and eight grandchildren.

Dr. John Alfred Froelich, 73-year-old Milwaukee surgeon, passed away on November 25, 1955, at a Milwaukee hospital after a short illness.

Doctor Froelich was born in Jackson, Wisconsin, on July 17, 1882. He attended the University of Wisconsin for two years and received his medical degree from Marquette University School of Medicine in 1908. He served a year's internship at Columbia Hospital in Milwaukee, and from 1918 to 1921 served a surgical fellowship at the Mayo Clinic, then moving to Milwaukee.

He had practiced at Princeton, Wisconsin, from 1910 to 1917. During the years from 1921 to 1933, Doctor Froelich lectured on surgery at Marquette University School of Medicine.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was also a member of the Wisconsin Radiological Society.

Surviving him are his widow, Irma; four brothers, Alfred B., Paul E., and George, all of Milwaukee, and Robert J. of Green Bay; and two sisters, Mrs. Amalia Gumm and Mrs. Minnie Schmidt, both of Milwaukee.

Dr. Philip Des Bois, 75-year-old Fond du Lac physician, died at a Fond du Lac hospital on November 26, 1955.

Born on April 18, 1880, at Montreal, Canada, he attended Laval University Medical School in Montreal and received his medical degree in 1904. He practiced at Beaverville, Illlinois; Peshtigo; Oconto; and Mazomanie prior to moving to Fond du Lac.

Doctor Des Bois was a former member of the Marinette–Florence County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

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1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.F.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M.J. *47*:858 (Sept.) 1954.
2. Moyer, J.H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.
3. Wilkins, R.W.; Stanton, J.R., and Freis, E.D.: Essential Hypertension. Therapeutic Trial of Veriloid, a New Extract of Veratrum viride, Proc. Soc. Exper. Biol. & Med. *72*:302 (Nov.) 1949.

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Survivors include his widow; two sons, Philip of Madison and Roger of Germantown; one granddaughter; two brothers; and several nieces and nephews.

Dr. John Edward Schein, Oshkosh, died at his home on November 27, 1955, at the age of 84 years.

Born on November 19, 1871, in the Town of Spring Prairie, Walworth County, he attended Milwaukee Medical College and received his degree in 1904. He returned to Oshkosh, where he had received his early education, and started his practice on the South Side. From 1918 to 1921 he operated the South Side Hospital.

Doctor Schein was city school physician for seven years, city physician and health commissioner from 1947 until 1951, and a former Winnebago County health officer.

He was a member of the Fifty Year Club of the State Medical Society of Wisconsin. He held membership in the Winnebago County Medical Society, was a life member of the State Medical Society of Wisconsin, and was a member of the American Medical Association.

He is survived by his widow, Laura; two sons, Norman and John; seven grandchildren; and six great grandchildren.

Dr. Robert Stephenson Ingersoll, Adams physician, died on December 5, 1955, at the age of 81 years.

Born in Adrian, Michigan, on January 12, 1874, he was graduated from the University of Michigan Medical School at Ann Arbor in 1898. He spent eight years in Calcutta, India, under the Foreign Mission Board of the Seventh-Day Adventists, and also had two years of postgraduate work in Chicago and London.

From 1910 to 1927 he served as surgeon and superintendent of the Seventh-Day Adventist–controlled hospitals and sanitariums in Washington, D. C.; Orlando, Florida; and Madison, Wisconsin.

Doctor Ingersoll was a licentiate of the Royal College of Physicians of London, England, and a member of the Royal College of Surgeons. He was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Prior to his move to Adams in 1949, he had practiced at Oxford, Plainfield, and Beloit. In 1951 he had retired from practice.

Surviving him are his son, Dr. B. P. Ingersoll of Adams, and a daughter, Mrs. Sarah Aho, Madison. His widow, Dr. Olive G. Ingersoll, died on December 20, 1955, two weeks after his death. She graduated from the same class in medical school as he did and was associated with him until 1941, when she retired because of ill health.

Dr. Elverse Morris Jordan, 59-year-old Green Bay physician, died on December 6, 1955, at a Green Bay hospital, where he had been hospitalized for about three weeks following a heart ailment.

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He was born December 18, 1895, in Elysian Fields, Texas, and received his medical degree from the University of Texas School of Medicine, Galveston, in 1923. He served his internship at John Sealy Hospital at Galveston and then began a three-year fellowship at the Mayo Clinic, completing it in 1928.

In 1928 Doctor Jordan, together with Dr. Ralph Troup and the late Dr. Carl S. Williamson, organized the Green Bay Clinic.

He was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association, and had served as president of his county medical society in the past.

Survivors include his widow, Lucille; his mother, Mrs. A. A. Jordan of Carthage, Texas; two sons, Elverse M., Jr., of Neenah, and Lt. Andrew A., an Army Air Force dentist stationed at Rapid City, South Dakota; a daughter, Mrs. James McNevins of Stamford, Connecticut; a brother, Wyse of Carthage, Texas; and a sister, Mrs. Murdoch Hunter, Marshall, Texas.

Dr. William Wencel Witcpalek, former Algoma physician, passed away on December 7 at a Green Bay hospital at the age of 84 years. Since his retirement in 1952, he had resided at Kewaunee.

Doctor Witcpalek was born July 10, 1871, at Rio Creek, Wisconsin. He received his medical degree from Northwestern University Medical School, Chicago, in 1911. He started practice at Collins in Manitowoc County, moving to Algoma in 1914.

He was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a life member of the State Society.

Surviving are his daughter, Dr. Ruth, a Chicago dentist; two sons, Dr. E. W. Witcpalek of Kewaunee and Lloyd of Green Bay; and eight grandchildren. His wife preceded him in death in 1941.

Dr. Carroll Dunham Partridge, retired Cudahy physician, died on December 12, 1955, at the age of 79 years.

Born in Bennington, Vermont, on July 11, 1876, he was graduated from Johns Hopkins University School of Medicine in Baltimore, Maryland, in 1908. While in college he did research on the enzyme, guanase. Information he found was later used in research at the University of Chicago and the Rockefeller Foundation.

He was an instructor in chemistry and bacteriology at the University of Michigan Medical School before moving to Cudahy in 1924. He had also been on the faculties of Cornell University, the University of Georgia, and Marquette. In 1923 he served an internship at Hanover Hospital in Milwaukee.

During World War I he was a lieutenant in the Navy. He also served as a bacteriologist with the Milwaukee Health Department during that time.

In 1954 Doctor Partridge was named "Kiwanian of the year" by the Cudahy Kiwanis Club. He had served as Milwaukee County physician for several

years, as school physician, and as city health officer. He and his wife conducted a maternity and first aid hospital from 1924 to 1940.

Doctor Partridge was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow; two daughters, Mrs. Christ Becker and Mrs. Arden Eichsteadt; a brother, George; and six grandchildren.

Dr. John James Minahan, Chilton, passed away at a Fond du Lac hospital on December 14, 1955, at the age of 67 years.

Born on May 9, 1888, at Chilton, Doctor Minahan received his medical education at Marquette University School of Medicine, from which he graduated in 1915. He practiced at St. Nazianz from 1916 to 1923, and in 1924 moved to Chilton.

Doctor Minahan was a member of the Calumet County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He had been a member of the Committee on Rural Health and Accident Prevention of the State Society in the past.

Survivors include his widow, Kathryn; four children, Lt. Col. John E., Washington, D. C., Mrs. John Durkin, Chicago, William, Chilton, and Patricia, Milwaukee; two grandchildren; and two sisters, Mrs. Michael Flaherty of South Milwaukee and Mrs. Eugene Chaney of Milwaukee.

Dr. Carl M. Becker, 48-year-old physician associated with the Veterans Administration Hospital in Madison, died December 20, 1955.

Doctor Becker was born in Freeport, Illinois, in 1907 and received his medical education at the State University of Iowa College of Medicine, Iowa City, graduating in 1933. Prior to joining the medical staff of the Veterans Administration Hospital in May, 1955, he practiced medicine in Freeport and served in the Army.

Doctor Becker is survived by his widow; a daughter, Mary; and two sons, Richard and Thomas.

Dr. Olive Grace Ingersoll, retired Adams physician, died December 20, 1955. She had been confined to the hospital for four years.

Doctor Ingersoll was born April 16, 1873, and was graduated from the University of Michigan Medical School in 1898 in the same class with her husband, Dr. Robert S. Ingersoll. She was associated in practice with her husband until four years ago, when ill health forced her to retire.

The Doctors Ingersoll spent eight years in Calcutta, India, as missionary doctors for the Seventh-Day Adventist Church. They later moved to London, England; Washington, D. C.; Richmond, Virginia; and Madison, Wisconsin. In 1930 they were associated in practice at Oxford, remaining there for 10 years. They moved to Plainfield in 1940, and in 1949 took up residence in Adams.

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Doctor Ingersoll is survived by her son, Dr. Birtis P. of Adams, and a daughter, Mrs. Sarah Aho, Madison. Her husband preceded her in death by two weeks.

Dr. Herman Charles Schumm, prominent Milwaukee orthopedic physician and surgeon, died at an Oconomowoc hospital on December 21, 1955. He was 66 years of age.

Doctor Schumm was born November 23, 1889, at Fort Wadsworth, Staten Island, New York. He received his medical education at the University of Pennsylvania School of Medicine at Philadelphia, from which he graduated in 1914. He served his internship at Augustana Hospital, Chicago.

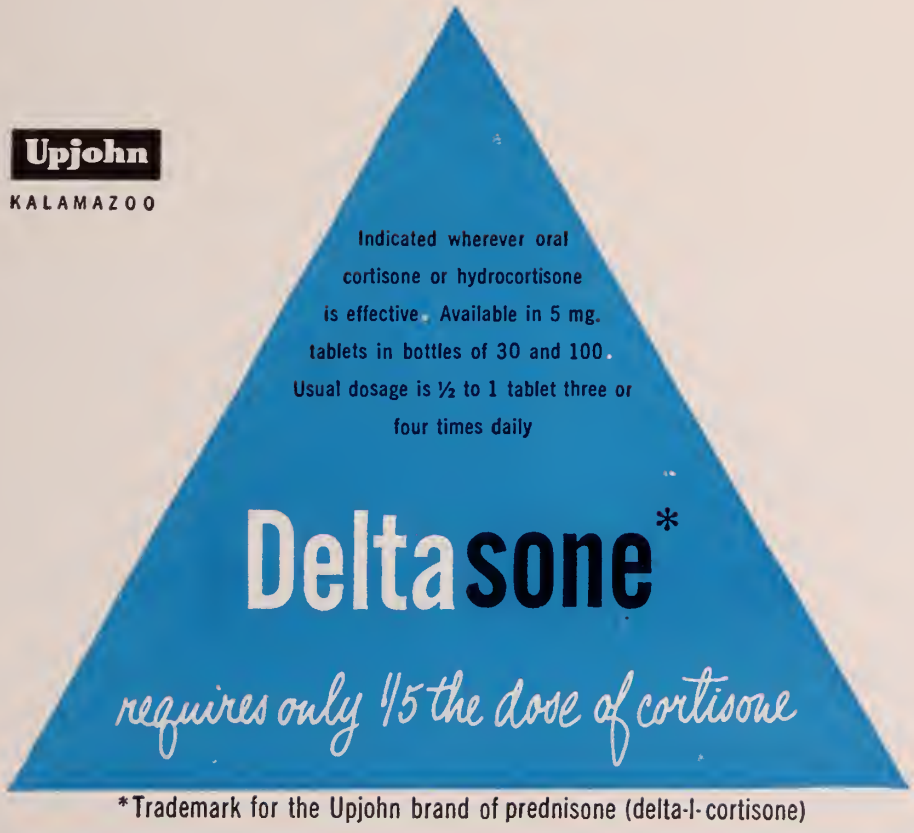
Until a month before his death he was associate professor of orthopedic surgery at the University of Wisconsin Medical School and clinical professor of orthopedic surgery at Marquette University School of Medicine. He headed the department of orthopedic surgery at Columbia Hospital, Milwaukee, and was on the attending staff of Milwaukee Hospital and Children's Hospital.

Doctor Schumm was a diplomate of the American Board of Orthopedic Surgery, and was a member of the American College of Surgeons, the American Academy of Orthopedic Surgery, the American Orthopedic Society, the Clinical Orthopedic Society, the Milwaukee Surgical Society, and the Milwaukee Academy of Medicine. He had served the Milwaukee Surgical Society as its president in the past.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Schumm started his practice in Chicago in 1914, then served as a captain in the Army Medical Corps in 1918–1919, and in 1919 came to Milwaukee, where he associated with Dr. Frederick J. Gaenslen.

Survivors include his widow, Sarah Jane; two sons, Herman C., Jr., of Fort Lauderdale, Florida, and David of Oconomowoc Lake; and a sister, Mrs. Gretchen Smith, Arlington, Virginia.



RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, October 21, 1955.

Name	*School of Graduation*	*Year*	*Address*
Darin, Joseph Chiono	Marquette University	1954	3019A N. 60th St., Milwaukee
Hampel, Donald Carl	University of Wisconsin	1954	3461 N. 16th St., Milwaukee
Lowenstein, Leah M. H.	University of Wisconsin	1954	2512 N. 46th St., Milwaukee
Ruetz, Philip Peter	Loyola University	1954	6714 W. Sheridan, Milwaukee
Stovall, William D., Jr.	University of Wisconsin	1944	South Dakota
Worman, Leonard William	Stritch School of Medicine	1954	8700 W. Wisconsin, Milwaukee

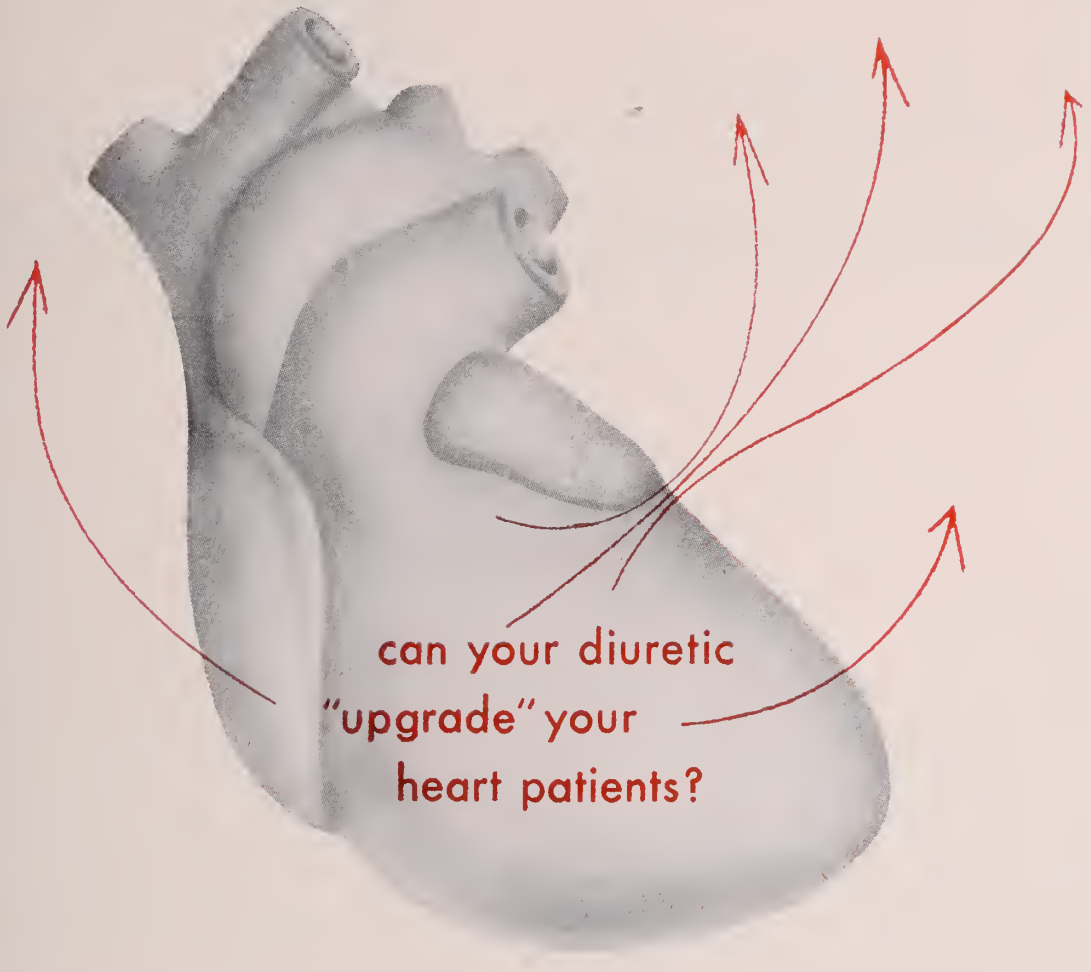
The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, October 21, 1955.

Name	*School of Graduation*	*Year*	*Address*
Anderson, Jack Gustav	Marquette University	1951	Irving Zuelke Bldg., Appleton
Becker, John Henry	Georgetown University	1949	Watertown
Belknap, Elston Lewis, Jr.	Johns Hopkins University	1949	231 W. Wisconsin, Milwaukee
Berman, Alexander	University of Wisconsin	1953	3963 N. Sherman Blvd., Milwaukee
Davis, Harry Louis	University of Illinois	1951	Monroe Clinic, Monroe
Doane, Joseph Chapman	Temple University	1948	University Hospitals, Madison
Doermann, Paul Edmund	University of Michigan	1951	Milwaukee County Hospital, Milwaukee
Gonty, Arthur Joseph	University of Manitoba	1935	Frontenac Beach, Menominee, Mich.
Grundset, Lloyd H.	College of Medical Evangelists	1944	Winfield Hospital, Winfield, Ill.
Herbert, Joseph William	Southwestern Medical College	1945	1146 Grant Street, Beloit
Jones, Harley Daniel	University of Illinois	1947	University Hospitals, Madison
Kundert, Elizabeth	Woman's Medical College	1926	Professional Bldg., Eau Claire
Lennon, Edward Joseph	Northwestern University	1952	1346 South 111th St., West Allis
Lyon, Mary Frances	University of Illinois	1951	840 South Wood St., Chicago, Ill.
Miller, Owen Edward	Loyola University	1946	425 E. Wisconsin, Milwaukee
Phelan, John Thomas	Marquette University	1947	Mayo Clinic, Rochester, Minn.
Quinn, Charles Stephens	University of Louisville	1942	405 E. Grand, Beloit
Stewart, Frederick J.	Northwestern University	1927	108 N. Tremont St., Kewanee, Ill.
Sullivan, Tullia T.	Loyola University	1942	9254 S. Winchester, Chicago, Ill.
Tashiro, Kazuo	University of Cincinnati	1944	19 S. Cleveland, Magadore, Ohio
Timp, Leo Frederick	Marquette University	1953	312B E. Plainfield, Milwaukee
Werner, Merrill John	University of Illinois	1933	1521 N. Main St., Dayton, Ohio
Wood, E. Hardenbergh	University of Maryland	1935	Jackson Clinic, Madison

POSTGRADUATE COURSE IN COMMON DIGESTIVE DISEASES OFFERED BY MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

A postgraduate course in common digestive diseases will be offered through the Marquette University School of Medicine, Milwaukee, on four consecutive Thursdays from 10:00 a.m. to 12 noon, starting April 5. The first three sessions will be presented in Room 109 of the medical school, the final session in the assembly hall of Milwaukee County General Hospital.

Joseph Shaiken, M. D., associate clinical professor of medicine at Marquette, will direct the course. M. C. F. Lindert, M. D., assistant clinical professor of medicine, will be co-chairman and a member of the faculty. Other faculty members for the course include Michael W. Shutkin, M. D., Robert E. Yunck, M. D., and Jack J. Levin, M. D., all assistant clinical professors of medicine at Marquette.



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Sell Diagnostic Benefits Under Both Plans

Last October the Commission on Prepaid Plans announced the sale of a Diagnostic X-ray and Laboratory Services Rider which is available to groups in addition to their basic Blue Shield coverage. Several thousand persons in Wisconsin already have the coverage. It should be emphasized that the Diagnostic X-ray and Laboratory Services Rider of Blue Shield is always sold with a similar rider to Blue Cross contracts. The Blue Cross and Blue Shield riders for this coverage must be sold as a package, thus assuring the subscriber diagnostic x-ray and laboratory services no matter where they are provided.

The Blue Cross rider provides allowances for diagnostic x-ray and laboratory services when performed in a hospital, and the Blue Shield rider provides such allowances when the services are performed and billed by a licensed physician and surgeon. The Blue Shield rider was described in detail in the October, 1955, issue of *The Wisconsin Medical Journal*, page 45. Copies may be obtained upon request to the office of the State Medical Society.

County Meeting Speakers

The Commission on Prepaid Plans urges all county societies to devote at least one meeting a year to discussion of Blue Shield. Please contact the State Medical Society office to make arrangements for speakers to discuss Blue Shield contracts, claims procedure, policy, proposals affecting health insurance, and the future of health insurance in Wisconsin. Please make requests at least two weeks in advance.

Insurance for Servicemen?

Congress is back in session, and there are several proposals of direct implication to Blue Shield. The President's health message did not reiterate a desire for some kind of effort to expand voluntary health insurance through mechanisms involving reinsurance. The so-called Vinson Bill proposes to utilize voluntary health insurance plans, including Blue Shield, as one of the means by which dependents of servicemen can be guaranteed medical and hospital care at government expense. Under such an arrangement, the serviceman would pay 30 per cent of the cost of the premium. At the same time, some consideration is being given to utilizing private insurance plans for the protection of the recipients of public assistance aids of one kind or another.

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Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Standard Values in Nutrition and Metabolism. Edited by Errett C. Albritton, A. B., M. D., Fry Professor of Physiology, The George Washington University. Prepared under the direction of the Committee on the Handbook of Biological Data, American Institute of Biological Sciences, The National Research Council. Philadelphia and London, W. B. Saunders Company, 1954.

This volume contains a comprehensive tabulation of available research data concerning the levels of all known metabolic constituents of body tissues and fluids in all major groups of animals. Comparable information is provided for many groups of plants, fungi, and micro-organisms. This includes vitamin and mineral contents of all plant and animal tissues, as well as biochemical compounds resulting from the metabolism of proteins, carbohydrates, and fats.

Because of the extremely detailed nature of these data, and especially because of the monumental bibliography which is included, the book will be of special interest to the investigator either in basic biological or in clinical science. By the same reasoning, it can hardly be expected to be of any significant importance to the average practicing physician.

All information is carefully and extensively documented so that it must be regarded as completely authentic. Careful indexing both by author and by subject adds greatly to the usefulness of the volume, and it can be recommended without reservation to all who are engaged in biological research.—E. S. G.

Reproductive System. Volume Two of the Ciba Collection of Medical Illustrations. Prepared by Frank H. Netter, M. D. Edited by Ernst Oppenheimer, M. D. Summit, New Jersey, Ciba Pharmaceutical Products, Inc., 1954. Price $13.00.

The general nature and purpose of this beautifully illustrated volume is well characterized in the foreword by Dr. John Rock, ". . . Doctor Netter marshalls able men of several disciplines, successfully to provide, within 270 quarto pages, an exceedingly compact and inclusive postgraduate course in both male and female reproductive anatomy, physiology and pathology." About 75% of the book concerns itself with pathology, about 17% is concerned with normal gross and microscopic anatomy, and around 8% is about evenly divided between development, diagnosis, and function.

The illustrations are ideal for the purposes intended. They are diagrammatically clear in both line and color, hence far from realistic when portraying internal anatomy. Many of those illustrating surface pathology are, on the contrary, so luridly lifelike that they would certainly be highly effective as antivenereal propaganda! The colored schemata illustrating functional or cyclical interrelationships are well conceived and executed, but often appear very complex (Section I, Pl. 3; Section VI, Pl. 26). Others are beautiful for their simplicity (Section IX, Pl. 14). Most of these are designed to illustrate only relatively elementary basic concepts but, even so, one must expect many of them to be hopelessly out of date in a few years.

Anatomically, the illustrations are generally both clear and accurate; but the text is not always so, perhaps in part from necessity for brevity and because of the assumption of previous knowledge on the part of the reader. One of the poorest portions, in both text and illustration, is on the homologies of the genitalia (Section I, Pls. 1, 2). Among the best illustrations are those on the normal male genitalia (Section II, Pl. 1–16). There is one minor inaccuracy here in that the continuity of Buck's fascia with the muscle fascias of the bulbo- and ischiocavernosus muscles is not indicated (Section II, Pls. 3, 4, 7).

The one major defect is the absence of references. This is said to be on the basis of space economy—certainly a poor excuse in a production as lavish as this one. Not only does lack of documentation detract immeasurably from its usefulness, even, I believe, to the purely clinical practitioner, but it puts a serious stigma on it as a scholarly and scientific work. Quite properly and inescapably such a book, both text and illustration, is based largely on previously published material. Aside from the question of giving credit where credit is due (sometimes an almost impossible and impractical task), things stated by either brush or type in any science demand specific documentation.—H. W. M.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

If you are married and want to step into an all-modern home and office and enjoy a good general practice, long established, this is your opportunity. No money required except for a nominal rental. May be purchased on long easy terms if desired. Office equipment will be financed for you if you wish. Owner retiring due to age and health. Address replies to Box 587 in care of the Journal.

WANTED: Resident physician, full or part time. Call or write Medical Director, Capitol Hospital, 1971 W. Capitol Drive, Milwaukee, Wis., Hi. 4-1400.

FOR SALE: Office equipment, complete, for 5 rooms. Includes portable (Fisher) x-ray machine, examining table, and new waiting room set. Address replies to Box 603 in care of the Journal.

FOR SALE: "Like new" G. E. electrocardiogram, equipped for unipolar leads. Price, $300. Address replies to Dr. J. C. Brazos, 406 S. Washington, Watertown, Wis

FOR SALE: 40-90 Meyer x-ray complete with table. Excellent condition. Contact Dr. A. F. Ottow, 550 East Grand Ave., Beloit, Wis. Phone Emerson 2-3342.

FOR RENT: Fully equipped office in village of 4,200 in Fox River Valley. No physician at present; owner has left to serve residency. Address replies to W. C. Verbrick, M. D., 126 E. Main St., Little Chute, Wis.

WANTED AFTER JULY 1: Recent graduate willing to do general practice in association with two doctors in new, completely equipped clinic which is located within one block of a general hospital. Address replies to Plymouth Clinic, Plymouth, Wis.

FOR SALE: All furnishings of a completely equipped, 18-bed hospital. Included are 18 beds and bedside cabinets, bedside rails, operating table, Castle operating room light, pin up lamps, Mayo tables, ring stands, instrument table, nurses chart desk, 15-button call system, nursery equipment (7 bassinets), and smaller utensils that are used in a hospital. Address replies to the Grant Community Hospital, Lancaster, Wis.

FOR SALE: Doctor's office in an almost new building which includes an apartment over the office. Apartment living room measures 17 by 20 and has fireplace. Present owner, who is selling because of ill health, is only M.D. in town. Town is surrounded by four villages which also have no M.D. Address replies to Box 630 in care of the Journal.

THREE GENERAL PRACTICE FELLOWSHIPS available at Monroe Clinic, Monroe (town of 7,000 with large rural and urban drawing area, 42 miles from Madison and 110 from Milwaukee). Training is of informal preceptorial type under qualified men in each field. Is not intended to qualify a man for any present-day board but rather provides rich experience in type of hospital-office-home practice general practitioner must do. Hospital work carried on in modern, 150-bed accredited hospital. Applicants must be eligible for Wisconsin license. Basic stipend, $3,600 per year. For further information write The Monroe Clinic, Monroe, Wis.

FOR SALE: 30 MA Continental x-ray and fluoroscope with Bucky table. Complete darkroom equipment. Price $850. Address replies to Box 629 in care of the Journal.

MEDICAL PHOTOGRAPHER (formerly with U. S Navy) desires full or part-time work. References, samples of color and black-and-white photography shown at first meeting. Willing to use personal equipment, consisting of complete 4 x 5 camera outfit, IIIF Leica and Exacta cameras, A. C. and D. C. electronic flash, and enlarger which doubles for copy outfit and is equipped to handle 35 mm and 4 x 5 negatives. Able to handle movie equipment. Now employed as a camera department manager. Over 9 years of experience in photographic field. Address replies to Box 618 in care of the Journal.

FOR SALE: Complete office equipment, including 30 milliampere G. E. x-ray with fluoroscopy, all darkroom equipment, new G. E. diathermy and E. C. G., instruments, laboratory equipment, 2 examining tables, desk, chairs, etc. Will sacrifice for quick disposal. Address replies to Box 619 in care of the Journal.

FOR SALE: Used standard flexray shockproof deep therapy x-ray unit—200 PkV-20 MA complete with vertical control and twin column tubestand. Price $1,500. Address replies to Hurley X-Ray Company, 2511 W. Vliet St., Milwaukee.

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. Permanent positions, under Civil Service. Salary depends upon previous experience and training. Housing available on grounds. Contact Dr. W. J. Urben, Superintendent, Madison 4, Wis.

FOR SALE: Entire practice and equipment of busy general practitioner. May lease some office space. Excellent opportunity for anyone starting in Green Bay, Wis. Owner must sell because of ill health. Address replies to Box 626 in care of the Journal.

FOR SALE: Used standard two-tube 100 MA x-ray unit with combination hand-tilt radiographic and fluoroscopic table and floor-to-ceiling radiographic tubestand complete. Price $1,600. Address replies to Hurley X-Ray Company, 2511 W. Vliet St., Milwaukee.

FOR SALE: Recent model Picker 100 MA Century complete with monitor control, combination radiographic fluoroscopic table with tubestand and shockproof tube, double focus. Price $2,250. Address replies to Hurley X-Ray Company, 2511 W. Vliet St., Milwaukee.

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FOR SALE: One Diebold Cardineer circular file in good condition—used about two years. Original cost, $365; will sell for $200, plus drayage. Address replies to E. O. Lukasek, M. D., 110 E. Franklin St., Sparta, Wis.

FOR SALE: Eye refracting equipment including Green's refractor, floor stand, projecto-chart, tonometer, streak retinoscope, power governor, and projection screen. All like new. $1,213 value for $850. Address replies to J. N. Moore, M. D., 3414 Monroe St., Madison, Wis.

LOCUM TENENS wanted for a general practice during month of July or August. Very attractive offer. Address replies to H. Y. Fredrick, M. D., Box 253, Westfield, Wis.

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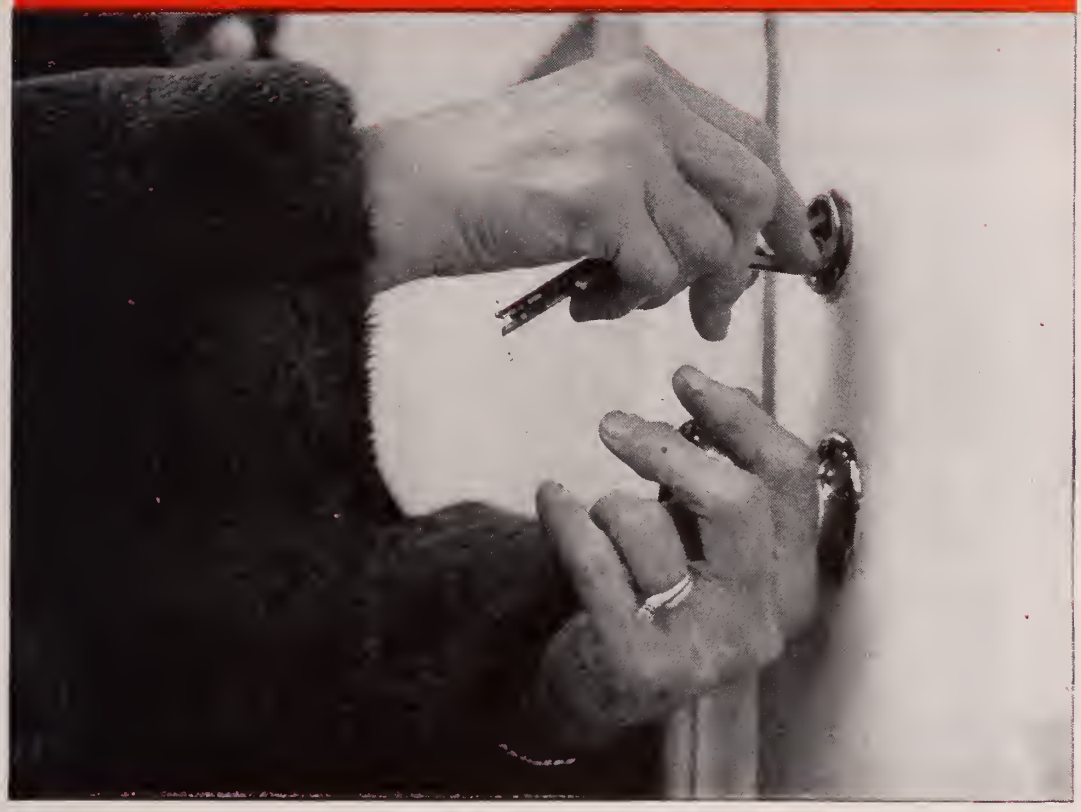

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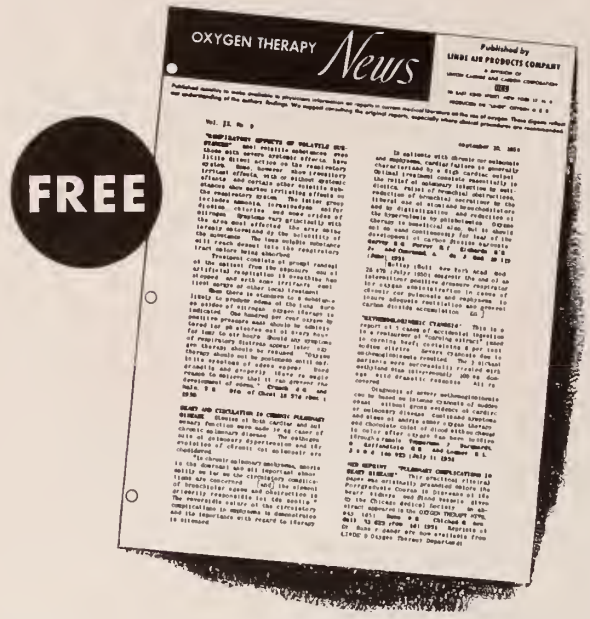
REFERENCES: 1. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952. 2. Ward, L. E., Polley, H. F., Slocumb, C. H. and Hench, P. S., *J.A.M.A.* **152**:119, May 9, 1953. 3. Snow, W. B. and Coss, J. A., *N.Y. State J. Med.* **52**:319, Feb. 1, 1952.



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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	152, 153
Ames Company, Inc.	214
Ayerst Laboratories	212
Baker Laboratories	238
Barr X-Ray Company	215
Benson Optical Company	230
Brown and Williamson Tobacco Corp.	228
Burroughs Wellcome & Co., Inc.	223
Ciba Pharmaceutical Products	144
Coca-Cola Company	209
Cook County Graduate School of Medicine	213
Davies, Rose & Co., Ltd.	227
Doerflinger Artificial Limb Co.	145
Endocrine Laboratories	210
Evron Company, Inc.	205
Foot-so-Port Shoe Company	212
Geigy Pharmaceuticals	211
General Electric	151
Haug Drug Company	216
Hotel Schroeder	210
House of Bidwell	226
Hurley X-Ray Company	212
Ivanhoe Sanitarium	213
Keeley Institute	230
Kennedy–Mansfield	218
Knox Gelatine	202
Lakeside Laboratories	241
Lederle Laboratories	198, 199, 229
Lilly, Eli and Company	158
Linde Air Products	246
Mallard, Incorporated	146
Mallatt Pharmacy	218
Mather Pharmacy	218
Mayo Clinic and Mayo Foundation	145
Mead Johnson and Company	247
Medical Protective Company	229
Milwaukee Sanitarium Foundation, Inc.	248
National Drug Company	219
New York Polyclinic	215
Orthopedic Appliance Company	215
Parke, Davis and Company	142, 143
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	150, 231
Physicians Casualty Association	236
Pogue, Mary E., School, Inc.	222
Professional Business Service	211
Rennebohm's	218
Riker Laboratories, Inc.	233
Rogers Memorial Sanitarium	248
Sacred Heart Sanitarium	234
St. Croixdale Sanitarium	145
Schering Corporation	148, 149, 156, 157
Schieffelin and Company	226
Searle, G. D. and Company	201
Sharp & Dohme	155, 235, 245
Shorewood Hospital Sanitarium	225
Smith, Kline & French Laboratories	217
Squibb, E. R., & Sons, Div. of Mathieson Chemical Corp.	221
Time Insurance Company	209
Upjohn	147, 239
Wine Advisory Board	154
Winthrop Laboratories, Inc.	208
Wisconsin Neurological Foundation	220
Wyeth	207

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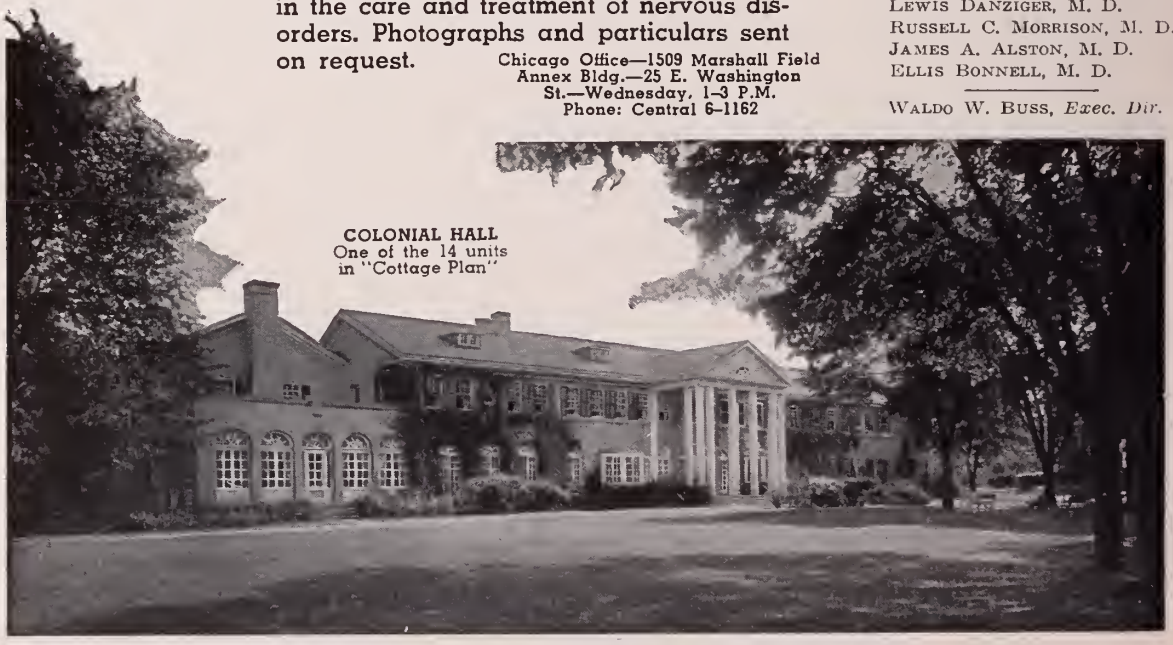

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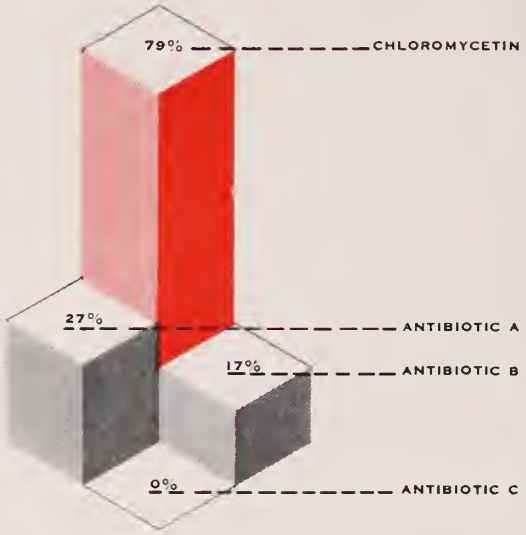

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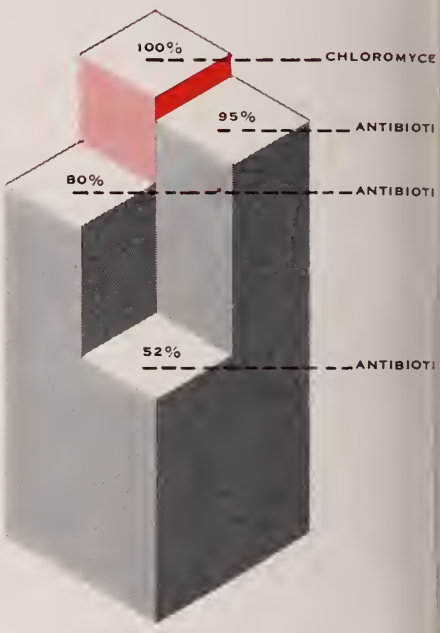

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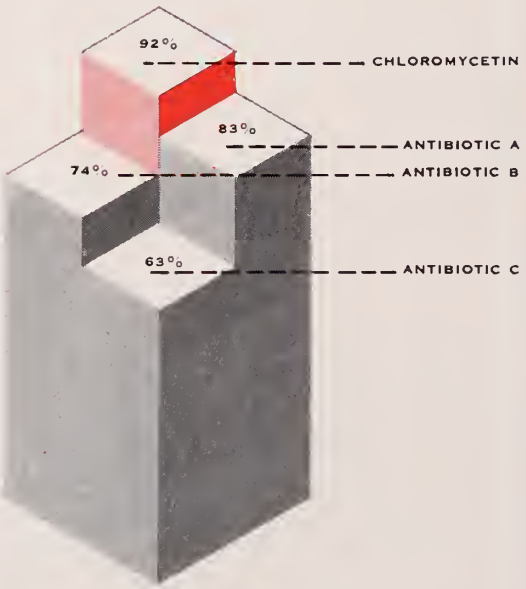

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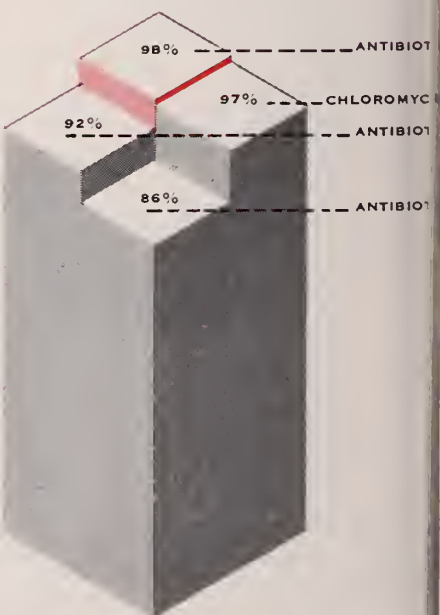

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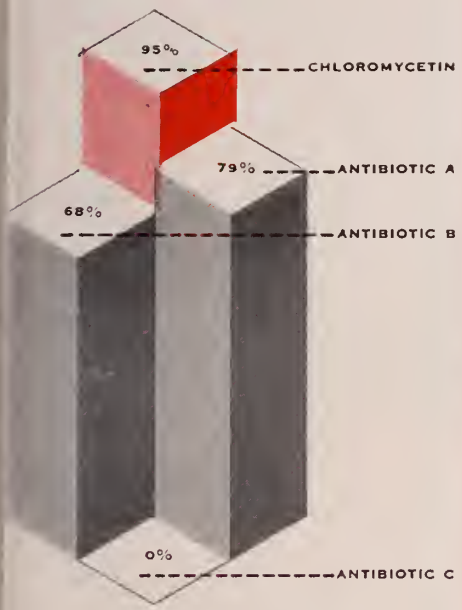

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references: (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (2) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (3) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (4) Austrian, R.: *New York J. Med.* 55:2475, 1955. (5) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, P. 557. (6) Felshin, G.: *J. Am. M. Women's A.* 10:51, 1955. (7) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (8) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159, 1955. (9) Stein, M. H., & Gechman, E.: *New England J. Med.* 252:906, 1955. (10) Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E., in Welch, H., & Marti-Ibáñez, F.: Antibiotics Annual, 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 1125. (11) Munroe, D. S., & Cockcroft, W. H.: *Canad. M. A. J.* 72:586, 1955. (12) Norris, J. C.: *M. Times* 83:253, 1955.

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

Modern Management of the Hypertensive Patient, by James A. Evans, M. D. ---------- 267

Weil's Disease; A Case Report, by Walter D. Shapiro, M. D., and Ralph Eugene Smith, M. D. 272

Comments on Treatment ---------- 277

The Failure of Testosterone Lotion to Aggravate Acne Vulgaris in Teen-age Males, by A. A. Holbrook, M. D. ---------- 304

Employee Health Services ---------- 306

Progress Report on the Wisconsin Maternal Mortality Survey, by the Study Committee, Division on Maternal and Child Welfare of the Commission on State Departments ------ 315

Clinicopathologic Conference ---------- 319

MISCELLANY

Page

1956 Annual Meeting ---------- 278
Society Proceedings ---------- 327
News Items and Personals ---------- 334
Third and Twelfth Districts News ---------- 337
Society Records ---------- 337
Obituaries ---------- 340
Facts About Wisconsin Physicians Service ---- 343
Correspondence ---------- 344
Physicians' Exchange ---------- 360
Index to Advertisers ---------- 362

EDITORIALS

Polls and Public Opinion ---------- 323
Interprofessional Cooperation ---------- 324
The President's Page ---------- 326

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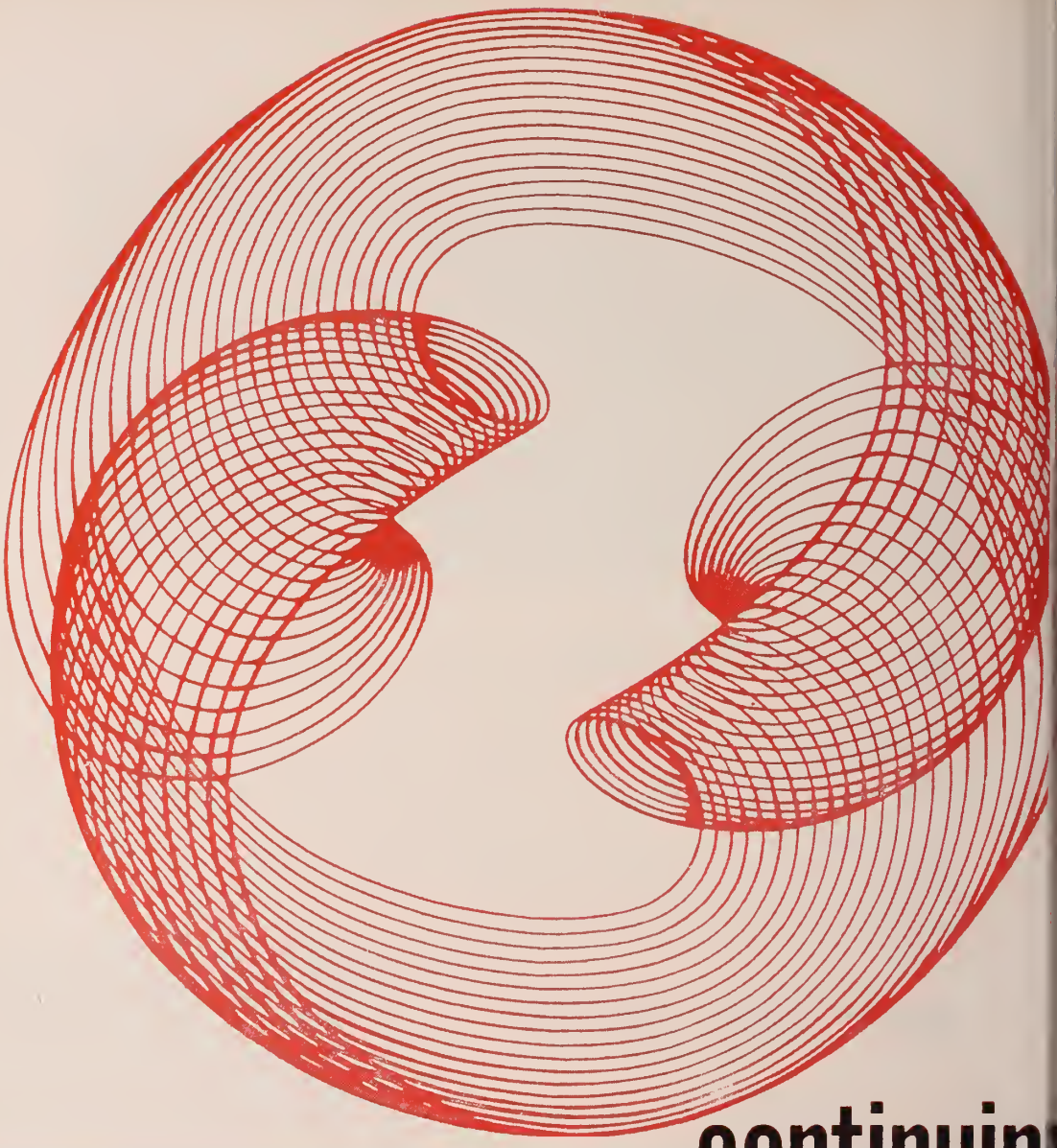

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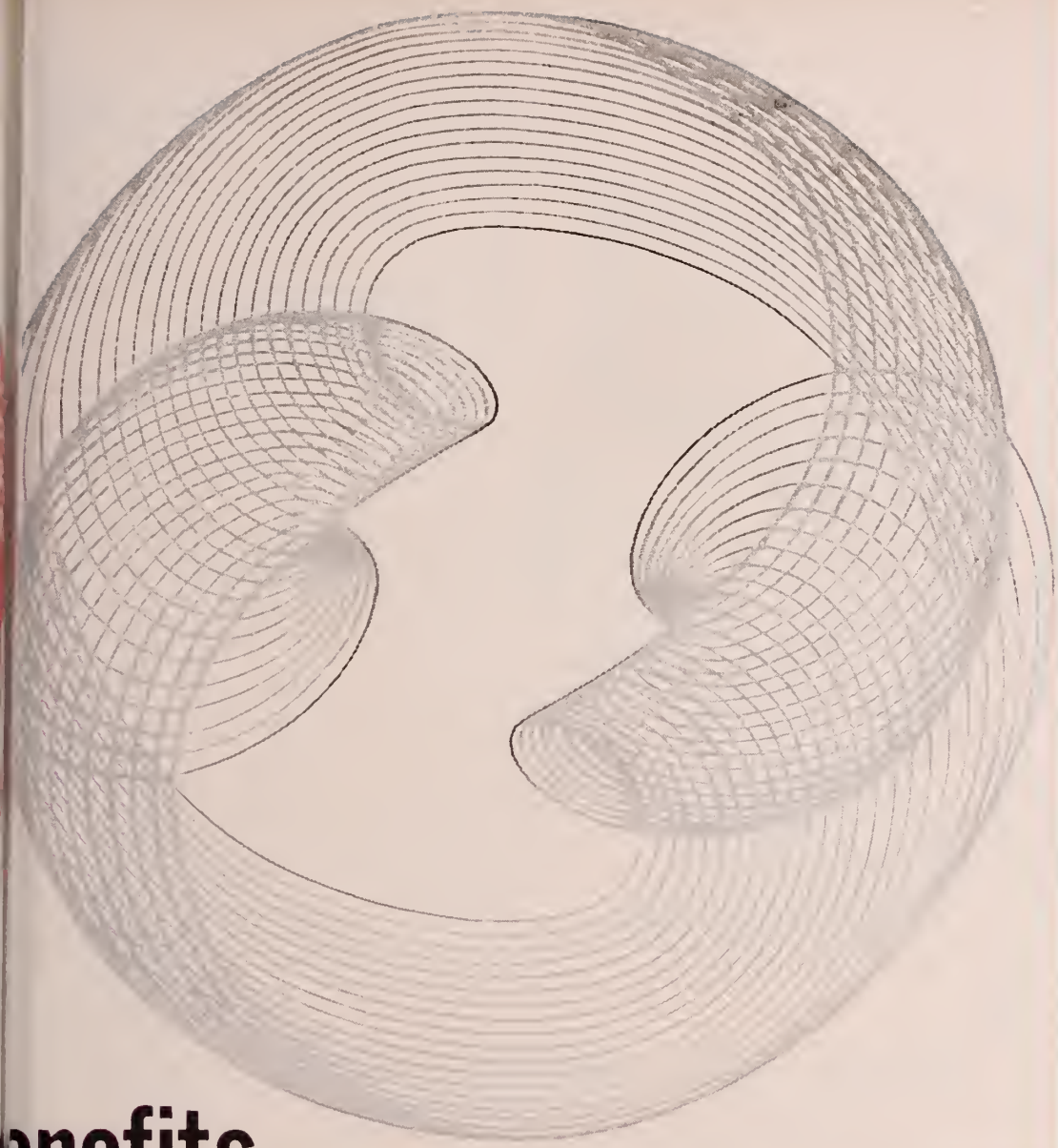

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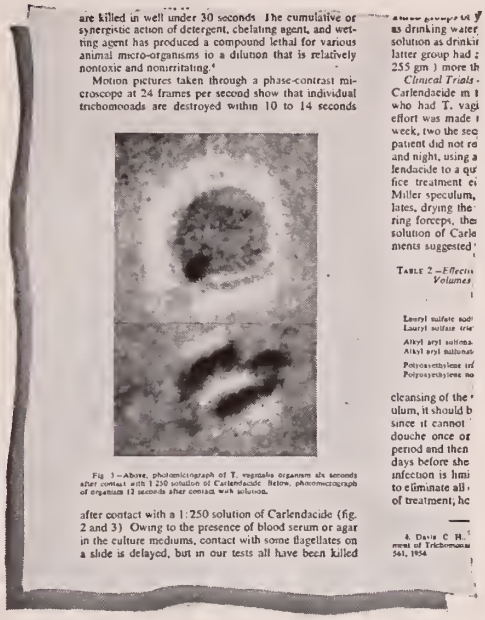

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Fig. 1.—Above, photomicrograph of T. vaginalis organism six seconds after contact with 1:250 solution of Carlendacide. Below, photomicrograph of organism 12 seconds after contact with solution.

as drinking water solution as drinkir latter group had 2 255 gm.) more th

Clinical Trials. Carlendacide in 1 who had T. vagi effort was made t week, two the sec patient did not re and night, using a lendacide to a qu fice treatment ei Miller speculum, lates, drying the ring forceps, then solution of Carle ments suggested

TABLE 2.—*Effects Volumes*

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4. Davis, C. H., ment of Trichomonas 541, 1954.

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Bibliography

1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 3. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 4. Davis, C. H.: J.A.M.A. *92*:306 (Jan. 26) 1929.

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On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q. i. d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

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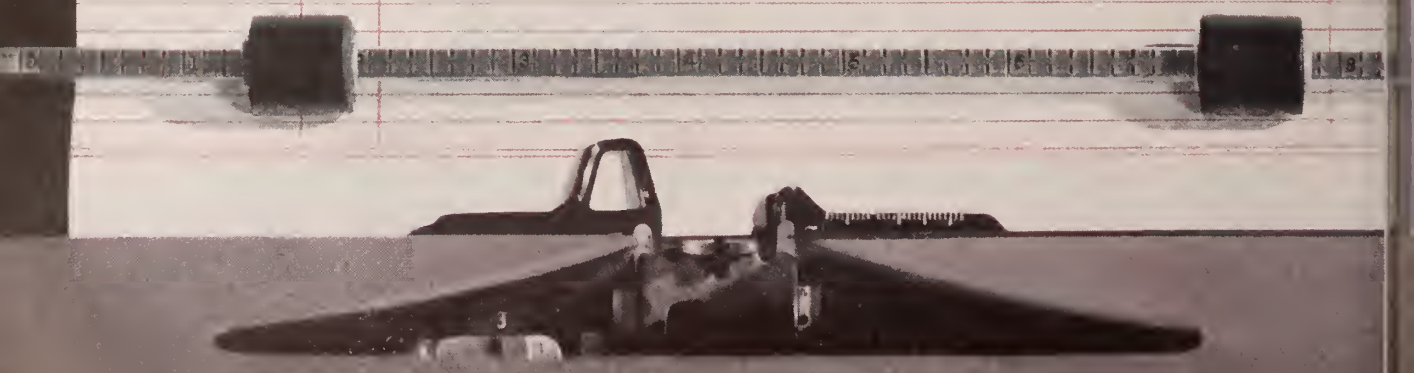

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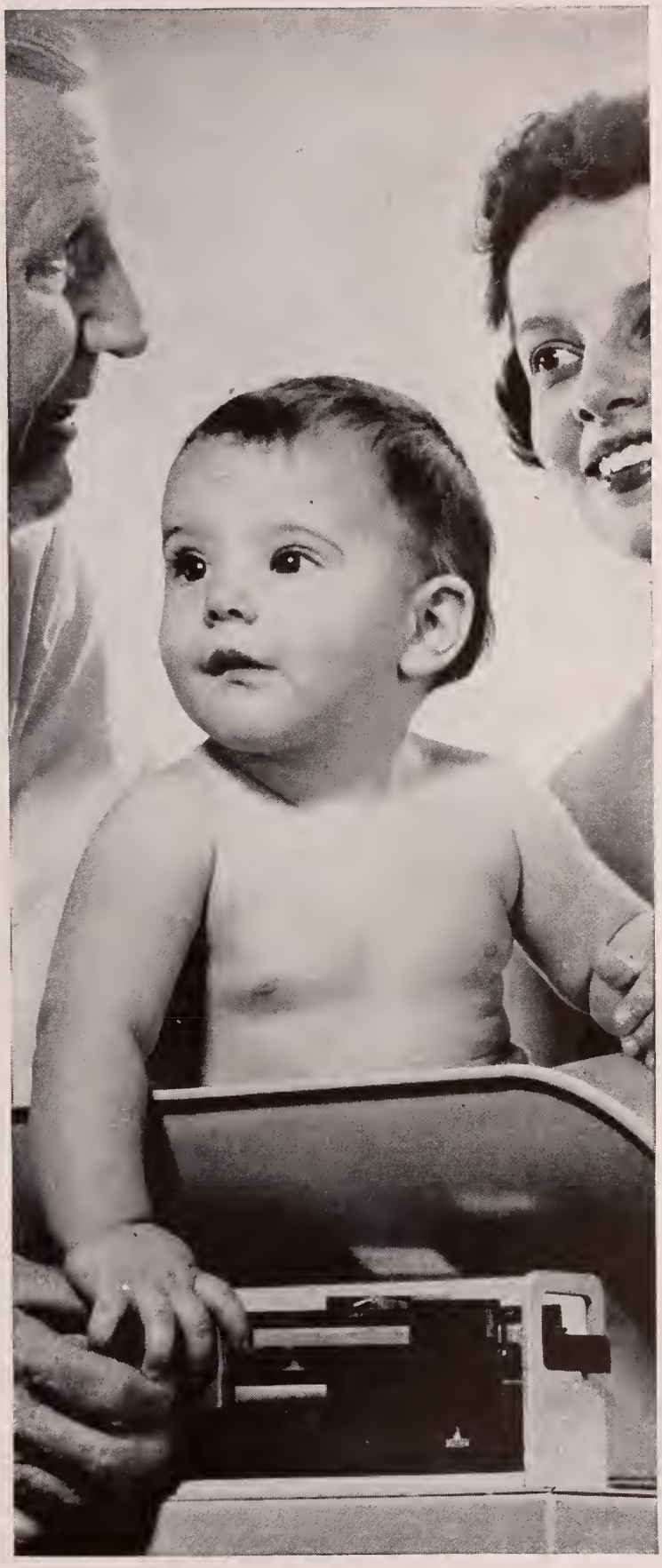

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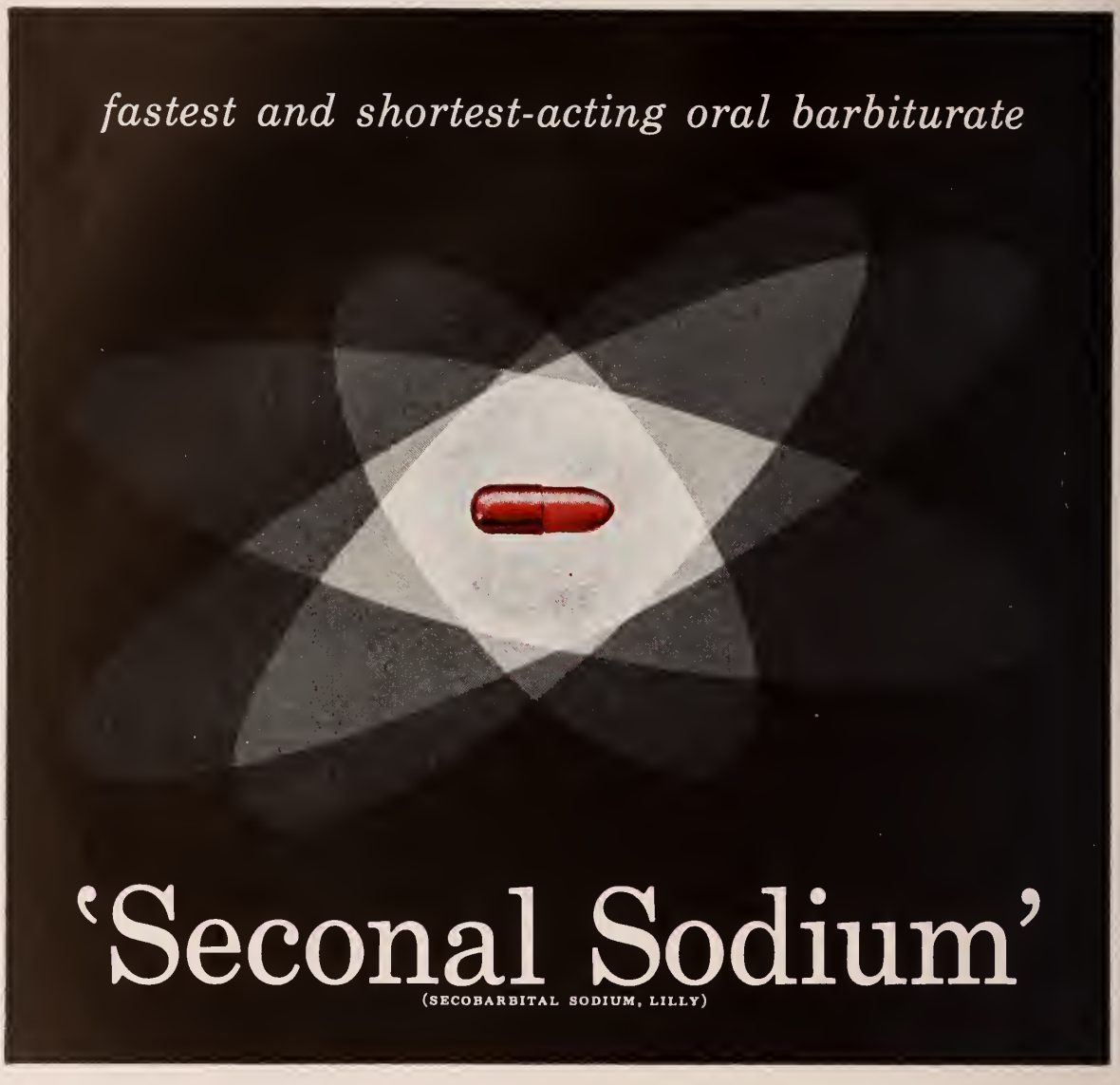

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Modern Management of the Hypertensive Patient*

By JAMES A. EVANS, M. D.
Boston, Mass.

WITHIN the past 20 years the treatment of hypertension has become effective. If splanchnicectomy for a few carefully selected cases is discounted, it is only within the past four years that effective drug therapy has been available. Before that time, over 200 preparations for the treatment of high blood pressure were listed in the U. S. Pharmacopeia. Many physicians, including the writer, were complete nihilists in their attitude toward the efficacy of those drugs.

Hypertension That Needs No Vigorous Treatment

In general, hypertension is a most overtreated disorder. It is important to consider which patients need no treatment before therapy of hypertension is discussed. There are three types of patients who have high blood pressure but not hypertensive disease.

(1) The **neurogenic labile hypertensive** who has sensitive vasomotor reflexes to his emotions. He flushes easily, he has a flushed capillary bed in the yoke area and face, his hands sweat when he is tense and have since he was a youngster in school reciting before his class, his pulse quickens easily, he sometimes has a tension tremor, and he often complains of cold feet. When he comes to the doctor's office his blood pressure is found to be elevated. All such patients should have a cold pressor test. There are two advantages to this test. It forces the examining physician to realize that when his patient is calm he does not have high blood pressure after all, and it shows that his blood pressure is labile to the shock of immersion of the hand in cold water. Often the rise of blood pressure to this physical shock is not so high as it is to the emotional shock of a visit to the doctor's office. To be sure, such patients are sometimes the human material in whom hypertensive disease finally develops, especially if there is a family history of high blood pressure. But most of these young persons should not be plied with drugs the rest of their lives; rather, they should be watched down through the years. They should have a careful annual physical examination and not be seen every few weeks, thus increasing their secondary anxiety, which will only enhance their tendency to hyperpiesis. At the first examination such a patient should have kidney function tests, the most important of which is a concentration test, for this is the first renal function to be diminished by the gradual onset of hypertensive nephrosclerosis. He should have an intravenous pyelogram to rule out polycystic disease or a Goldblatt kidney. A 7-foot chest plate and an electrocardiogram should also be obtained. Above all, a careful note must be made concerning the status of his retinal vessels as seen with the ophthalmoscope. The chief importance of these data is to serve as a base line for comparison in the future. When he first shows signs of cardiovascular or renal degenerative disease or a tendency for the resting blood pressure to remain high, then alarm must be taken and the patient should be wedded to drug therapy or, perhaps, if necessary, should undergo splanchnicectomy.

* * *

(2) The second type of patient in whom overtreatment is so often an abuse is the elderly man or woman with only a **systolic type of hypertension** due to arteriosclerosis. In this type of patient the normal standard of blood pressure has been raised. A woman of 60, for instance, is entitled to 175 mm.

* Presented at the One Hundred and Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 4, 1955.

systolic and 100 mm. diastolic and should not be considered to have hypertension until the blood pressure is 190 mm. systolic and 110 mm. diastolic. Commonly, a patient with arteriosclerosis will have a blood pressure of 210 mm. systolic and 100 mm. diastolic and may already have had a cerebrovascular accident. He has not had a cerebral thrombosis, the most common vascular episode in the hypertensive, arteriosclerotic brain, because he has high blood pressure, but because he has atherosclerosis of his cerebral arteries. It is a mistake in such a patient to attempt to maintain a normal blood pressure with our modern drugs. He needs this systolic head of pressure to force blood through a narrowed arterial bed. If he needs sedation for anxiety, the Rauwolfia drugs fortunately will not lower this systolic head of pressure very much and may be given safely. The ganglionic blockers are dangerous. Unfortunately, there is no drug which will guarantee against a recurrence of cerebral thrombosis in his atheromatous arteries. Splanchnicectomy will not give this guarantee either. Control of weight by the avoidance of fatty, high cholesterol foods may slow up the development of atheromatous disease; and such disease is the most important indication for fat-restricted diets. In our experience, rutin is of no value in preventing strokes or altering hemorrhage in the fundi. We do not use it any more, believing it is a useless expense.

If, however, the patient has fugitive cerebrovascular episodes associated with a sustained high diastolic pressure and the state known as cerebral encephalopathy, then the pathological background is different from that of atheromatous disease. In such cases we believe the symptoms are more likely to be due to small areas of perivenous or periarterial hemorrhage or exudate of the same nature as can actually be seen in Grade III or IV hypertensive retinitis. This pathological picture is the more strongly suggested if the symptoms of encephalopathy and these retinal changes are present at the same time. Since much vascular retinal change spectacularly disappears under treatment, both medical and surgical, such patients should be vigorously treated.

* * *

(3) The third type of patient who often needs only the mildest of medical management, and in many cases none at all, is the middle-aged woman who, when first seen, has a blood pressure level at rest of 180 to 200 mm. systolic and 100 to 120 mm. diastolic, who has had high blood pressure for five to ten years, and who, after careful survey of heart, blood vessels, and renal function, is found to have as yet no cardiovascular renal degenerative disease. She often has chronic nervous exhaustion from an anxiety state, usually situational in origin. She has nuchal occipital headaches from nervous tension rather than from high blood pressure. She has morning fatigue and gathers more energy during the day. She sighs often and may be in the menopause. The prognosis in such a case almost invariably is good. Many of these patients survive into the 80's and 90's. One such old lady survived to 97.[1] Life insurance statistics bear this out, and the durable vascular system of the human female is the principal reason more wealth in the country is owned by women than by men. Again, Rauwolfia may prove to be of value both as a sedative and in lowering the blood pressure, but it should not necessarily be lowered to normal levels. Weight control, however, is again the chief indication. Treatment of menopausal symptoms helps decrease nervous tension.

Hypertension That Needs Vigorous Treatment

Now let us consider the hypertensive patient who really needs vigorous treatment. Here, a knowledge of the grading of hypertension is a necessity, and that is based on a study of the eyegrounds. Most systems advocated are too complicated for the busy practitioner's office. If he is going to treat patients with hypertension, however, he must be able to classify eyegrounds. Grade I shows arteriolar sclerosis without compression at the arteriovenous crossings; Grade II shows such compression; Grade III has the added feature of hemorrhage or exudate; and Grade IV the added feature of choked disks. Patients with Grades III and IV hypertension invariably have a poor prognosis, their high blood pressure is often called "malignant hypertension," and they need vigorous treatment.

Patients with Grade I hypertension usually belong to the types discussed in the first part of this article. Those with Grade II hypertension usually have diastolic pressures of over 110, but the blood pressure is still

fairly labile, although it rarely reaches normal at rest.

By vigorous treatment we mean administration of any drug or combination of drugs that will make the patient live at a diastolic pressure of 90 to 110, which is our goal, or surgery—splanchnicectomy or splanchnicectomy and adrenalectomy.

Those who need such treatment are, first, the patient with Grade II fundi who has symptoms such as severe headache, dizzy spells, fugitive episodes of hemiparesis or hemianesthesia, episodes of nocturnal orthopnea indicative of left ventricular failure, a history of coronary occlusion, early or total congestive failure, angina, increasing exertional dyspnea, or recent development of nocturia two or three times a night. If his cardiovascular renal survey shows abnormal neurological signs, enlarged heart, the electrocardiographic pattern of left ventricular hypertrophy or so-called "strain," nonspecific changes probably indicative of coronary disease, or a frank myocardial infarct, he must have vigorous therapy to prolong his life. If the renal functional tests show beginning nephrosclerosis, he should be treated vigorously.

In case the patient already has irreversible azotemia, the ganglionic blockers are used with caution. Rauwolfia is harmless, although usually ineffective. Apresoline, always in doses under 200 mg. per day, may increase renal blood flow and glomerular filtration. A low sodium diet of 200 to 400 mg. per day may be helpful in keeping the chronic azotemic patient alive for three to five years providing he is not a "sodium loser." Therefore, an occasional urinalysis of a 24-hour specimen for sodium content is necessary to be sure he is successfully keeping his sodium intake minimal. A total of 10 to 25 mEq. in a 24-hour urine specimen reflects a sodium income of less than 0.5 gm. a day. When the patient is first placed on a low sodium diet, frequent estimations of serum sodium and nonprotein nitrogen are a "must" to prevent the catastrophe of hyponatremia which will only increase azotemia and the danger of uremia. A really low sodium diet is automatically low in protein because all animal products are high in sodium. Sodium diets must be low, under 0.5 gm. per day, to be effective in hypertension; and this requires careful cooperation on the part of the patient and very careful instruction on the part of his physician.

The second type of patient for whom vigorous treatment is indicated is any patient with hemorrhagic fundi. Such patients comprise the Grade III and Grade IV groups who have malignant hypertension.

Choice of Treatment: Shall It Be Drug Therapy or Splanchnicectomy?

Splanchnicectomy in our hands and in those of many others has improved the survival rate in patients with malignant hypertension who still have good kidney function, and in those who have developed moderate cardiac degenerative disease, including angina. We must not abandon this operation entirely, in spite of the success of modern drug therapy.

Ten years after operation for Grade III hypertension, half of the patients are still living, whereas none would be expected to be alive with the old methods of treatment. At 10 years about one-third of the patients operated on for Grade IV hypertension survive, when, according to Keith, Wagener and Barker, almost all are dead within three years with the old medical therapy.[2]

It is too soon to compare accurately the survival rates of surgically treated patients with the rates of those treated by modern drug therapy, but this method, too, is meeting with promising success. Of 78 consecutive patients with malignant hypertension treated with different combinations of Rauwolfia, Apresoline, and the ganglionic blockers hexamethonium and pentolinium (Ansolysen), 55 (70 per cent) survived from three months to three years and 17 (22 per cent) died; 6 patients were lost to follow-up.[3] Patients with hemorrhagic fundi were chosen for survival study since they offer the best test for the efficacy of any form of therapy because of their relatively short survival if not treated by modern methods.

We still urge splanchnicectomy for the young, otherwise vigorous patient with malignant hypertension with hemorrhagic fundi if he still has good kidney function, rather than subject him to drug regimen for the rest of his life. If the patient insists, we try the drugs first. Indeed, sales resistance to splanchnicectomy has grown tremendously since the advent of the drugs. Our splanchnicectomy operations have decreased from 49 in 1951, the first year we employed

the drugs, to only 8 in 1954. These operations were on patients all of whom were dangerously ill with malignant hypertension but who still had fair kidney function with normal nonprotein nitrogen and good concentration of the dye in the intravenous pyelogram. If they had congestive failure, either a total adrenalectomy was done at the same time or one adrenal was taken out at the second stage. The removal of one adrenal gland is done not with the expectancy of altering the patient's physiology, but in order to complete a total adrenalectomy a few months later, should the splanchnicectomy, addition of low sodium diet, and a postoperative trial on the hypotensive drugs prove insufficient. Total adrenalectomy is reserved for patients with congestive failure only, because of its profound effect of preventing sodium retention, with consequent edema.

It should be noted here that the hypotensive sensitivity of patients who have undergone splanchnicectomy is greatly enhanced by sodium restriction, weight reduction, and all the hypotensive drugs. The use of the latter often precipitates profound postural hypotension so that precaution in dosage must be exercised, even with Rauwolfia.

When the hypertensive patient has angina decubitus or angina on the slightest provocation, either exertional or emotional, splanchnicectomy and sympathectomy, including the anginal pathway from the first through the fourth thoracic vertebra, has proved 90 per cent effective in either totally abolishing or greatly diminishing the pain. This is not so true in angina without hypertension.

Splanchnicectomy has reduced cardiac size in 90 per cent of the patients having enlarged hearts, in 50 per cent to normal size, as noted on a 7-foot chest plate.[4]

Choice of Patients for Drug Therapy and Method

Rauwolfia is the only one of the new drugs that can be casually prescribed across the consultant's table. Apresoline demands close watching for toxic effects. It causes headache so often that the patient should first be primed with Rauwolfia. Apresoline should never be used in doses of over 200 mg. per day because it may cause a rheumatoid form of arthritis, even pancytopenia and collagenous syndrome. Patients taking Veratrum must be watched for nausea. If the ganglionic blockers are used, we insist on hospitalization, education, and the keeping of blood pressure charts by the patient for a few months after he returns to his home. He should keep such a chart one day a week the rest of his life as does the diabetic patient with his sugar and insulin chart. Since blood pressure levels taken in the physician's office are subject to rises from anxiety, it is impossible to judge the blood pressure level the patient may have at home. Thus, the physician may order larger doses of the ganglionic blockers and cause serious postural hypotension, or he may abandon treatment that is really highly successful.

Rauwolfia is preferred for patients with mild Grade I hypertension of neurogenic origin if treatment other than regulation of the general rules of living is required.

Rauwolfia is used for "priming" purposes in all patients. It should be remembered that it takes two to three weeks to have much effect on the blood pressure. Thus, we always have the patient take Rauwolfia for two weeks before he is admitted to the hospital. In the hospital we determine the most effective combination of drugs and what dosage is needed. Unless a marked sedative effect is indicated, we use an unrefined Rauwolfia because it is cheaper. If the patient returns in two weeks with satisfactory blood pressure and symptomatic response, hospitalization is cancelled.

If the hypertension is not very severe and blood pressure response to Rauwolfia alone has not been satisfactory, yet hospitalization is deemed unnecessary, Apresoline is added, starting with 25 mg. three times a day and working up to 50 mg. three times a day. If this drug is not well tolerated, a Veratrum product is used in combination with the Rauwolfia, working up to 3 units four times a day unless nausea intervenes. This happens so often in doses effective on blood pressure that we seldom use Veratrum now. There is some doubt in our minds that a drug as potentially toxic as Apresoline should be used over a period of years.

The only pill combining several drugs that we prescribe over the office desk contains Rauwolfia, Veratrum, and Dibenzyline, and is used only in mild cases.

For the patient with severe hypertension, the one we used to submit so often to splanchnicectomy, we prefer the ganglionic blocker pentolinium (Ansolysen) after priming two weeks with Rauwolfia. We advocate the method of Smirk,[5] having the patient learn to take his own blood pressure in the standing position because too much postural hypotension must be avoided. If the standing blood pressure falls below 150 mm. systolic, he must halve the next dose. If it falls below 120 mm. systolic he must omit the next dose and halve the one after that. We start with 20 mg. orally and increase each dose, 20 mg. at a time, if the blood pressure stays above 160 mm. systolic. Doses of over 100 mg. four times a day are rarely necessary.

The Role of a Low Sodium Diet

A careful follow-up study was made of 60 patients with hypertension of all grades on as low a sodium intake as they could achieve at home. An occasional urinalysis of a 24-hour specimen showed that most of these patients really did succeed in decreasing their sodium intake to about 0.5 gm. per day. An attempt was made to obtain a subsequent drop of the diastolic pressure of only 20 mm.; only 13%, however, achieved such a decrease. We believe the natural fluctuations of office blood pressure readings would account for such a drop in 13%. Therefore, as a practical measure for the average hypertensive patient, the low sodium diet taken at home for the remainder of the patient's life is not worth the penance. It does enhance the postural hypotensive drop of both medical and surgical splanchnicectomy. Too low a sodium intake may cause too much of a drop with the ganglionic blockers. It may restore the postural hypotensive decrease that has been lost in the splanchnicectomized patient. It is useful in the edematous patient, and we found it caused a drop in diastolic pressure of 20 mm. or more in about 25% of the cases of hypertensive patients with edema.

Summary

Many patients with hypertension do not require treatment or can be treated with simple measures. Included in this group are: (a) patients with vasomotor instability and a labile blood pressure that falls to normal on rest; (b) patients with arteriosclerosis and systolic hypertension, and (c) obese menopausal women with labile blood pressure which has been present for years without the development of cardiovascular or renal degenerative disease. Hormones, sedatives, weight control, and sometimes Rauwolfia are indicated.

Splanchnicectomy is indicated in: (1) the young person with malignant hypertension who still has fair kidney function; (2) the patient under 50 who has an enlarged heart or episodes of left ventricular failure, with good renal function, who tires of the medical regimen or in whom the medical regimen is unsuccessful; (3) the patient with fugitive cerebrovascular episodes who fails to respond to, or tires of, the medical regimen; (4) the patient who might have intractable headache in spite of modern medical regimen; (5) the patient whose angina does not subside under a medical regimen but who has not had a myocardial infarction recently; and (6) the patient with congestive heart failure and hypertension to whom, in desperation, splanchnicectomy plus total adrenalectomy may be offered when it is thought that a trial of medical therapy would take too long to save him.

In all these categories renal function must be good enough to show adequate concentration of the dye on the intravenous pyelogram, and no azotemia should be present. Those patients in whom the specific gravity of the urine is over 1.020 have the best prognosis after splanchnicectomy.

The most effective drug for severe cases of hypertension in our hands has been Rauwolfia, followed by pentolinium.

We consider it necessary to educate the patients to keep their own blood pressure charts at home in order to control dosage accurately.

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REFERENCES

1. Wakefield, H.: High blood pressure in older women, Postgrad. Med. 16:175–177 (Sept.) 1954.
2. Keith, N. M., Wagener, H., and Barker, N. W.: Some different types of essential hypertension: their course and prognosis, Am. J. M. Sc. 197:332–343 (March) 1939.
3. Burnett, C. F., Jr., and Evans, J. A.: Drug therapy in hypertension with hemorrhagic hypertensive retinitis, New England J. Med. 253:395–398 (Sept. 8) 1955.
4. Evans, J. A., and Bartels, C. C.: Results of high dorsolumbar sympathectomy for hypertension, Ann. Int. Med. 30:307–329 (Feb.) 1949.
5. Smirk, F. H.: Practical details of treatment of hypertension by hexamethonium salts and by pentamethylene 1:5-bis-N-(N-methyl-pyrrolidinium) bitartrate (M. & B. 2050A), New Zealand M. J. 52:325–348 (Oct.) 1953.

Weil's Disease*

A Case Report

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LARSON of the U. S. Public Health Service in 1941 received three separate serum specimens from the Milwaukee area with diagnostic titers to *Leptospira icterohaemorrhagiae*,[1] but no case of Weil's disease has been reported from Wisconsin or Minnesota.

A Wisconsin resident was recently admitted to a Minnesota hospital, where Weil's disease was diagnosed.

Case Report

A 74-year-old laborer was admitted to the U. S. Veterans Administration Hospital, Minneapolis, Minnesota, on Oct. 21, 1954. He was in good health until one week prior to admission, when he suddenly developed fever and chills. The following day he took six quinine tablets. The fever subsided but weakness; generalized myalgia, worse in the lower back; anorexia; and nausea without vomiting appeared. On the following day the patient's urine was dark and his stools light. Pruritus and decreased urine output were noted for a day or two prior to admission.

The patient lived in a small wooden shack on the bank of the Mississippi River and on many occasions waded in the mud at the bank of the river edge where he had often seen many rats. He maintained several rats and a skunk as pets. A history of vomiting after excessive alcoholic ingestion, which was frequent, was also obtained.

Physical examination at the time of admission revealed an icteric, lethargic, white male in moderate distress and appearing seriously ill. Vital signs were normal except for a temperature of 100 F. Minimal conjunctival injection was noted. There was guarding throughout the abdomen, and the liver was palpable just below the right costal margin. The bladder was not distended. There was bilateral paravertebral tenderness in the lumbar region. Marked tenderness was elicited on palpation of the bodies of the biceps muscles bilaterally, especially on the right; and there was mild tenderness of the triceps on the right. Numerous petechiae and ecchymoses were observed over the trunk and extremities. An area of hemorrhagic excoriation about 10 cm. in diameter was noted over the lower abdomen in the midline. No spider nevi were seen. Multiple soft subcutaneous masses, interpreted as lipomata, were present on the anterior abdominal wall.

Laboratory studies done at the time of admission included a urinalysis which showed a 4+ albuminuria, concentration of 1.020 with granular casts and a few white blood cells, and positive reaction for bile. The admission white blood cell count was 23,000 with 99% neutrophils. The hemoglobin was 12 gm., platelets 53,000, sedimentation rate 100 mm. in one hour, blood urea nitrogen 105, CO_2 21, chlorides 95, fasting blood sugar 128, serum albumin 3.3, serum globulin 3.0, serum bilirubin 9.1 in one minute and 14.5 total, cephalin flocculation 3+ and 4+, thymol turbidity 11.4, and alkaline phosphatase 14 KA units. Blood cultures and repeated urine cultures were negative. The initial electrocardiogram showed a pattern consistent with hypokalemia. Initial radiographic examinations included a normal chest film and normal abdominal films. Agglutination titers for leptospiral organisms reported later showed low titers without significant change for *L. ballom, andaman, semeranga, sentot, autumnalis AB* and *canicola*. The initial titer on Oct. 25, 1954, for *L. icterohaemorrhagiae AB* was 1:400. This rose to 1:1600 on November 1 and November 8 and returned to a level of 1:400 on November 10. The subsequent pertinent laboratory studies are illustrated in figs. 1 and 2.

The patient was started on oxytetracycline, penicillin, and symptomatic therapy. On the first night epistaxis with an esti-

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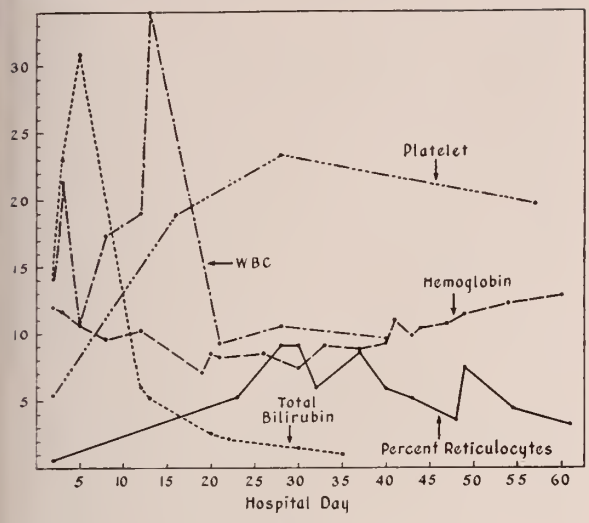

Figure 1

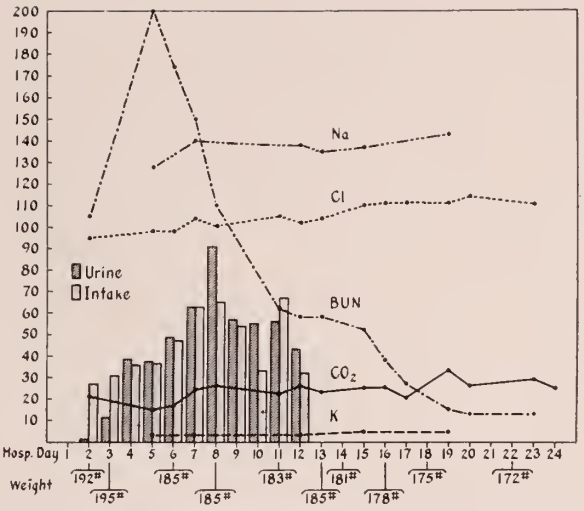

Figure 2

mated minimal blood loss occurred. Because of the manifest bleeding and thrombocytopenia, cortisone therapy was started. The epistaxis did not recur, and the platelet count soon rose to over 100,000. After several days cortisone therapy was discontinued. The oliguria noted at the time of admission continued until the second hospital day, when an output of 1,100 ml. was recorded. Thereafter polyuria was present. In the early diuretic period blood urea nitrogen continued to rise, but subsequently fell. During this time the patient's protein intake was restricted, and fluid and electrolyte therapy was administered parenterally. By the third hospital day the patient's temperature had returned to normal. Nonetheless, he continued to be critically ill until the beginning of the second week. Anemia developed and although tetracycline therapy negated the value of fecal urobilinogen measurements, it was considered probable that the patient's anemia had a hemolytic basis as evidenced by a progressive drop in hemoglobin and constant reticulocytosis without demonstrable blood loss. When the hemoglobin reached a level of 7.7 gm.%, the patient was given 300 ml. of packed red blood cells. The Coombs' tests were repeatedly negative. A lumbar puncture was attempted but was unsuccessful. Guinea pig inoculation of the urine was not done.

This patient gradually improved, and on December 15 a biopsy of the right biceps muscle showed occasional focal, small and medium-sized vacuoles in the muscle fibers. Interspersed among the muscle fibers were masses of proliferating sarcolemmal cells. Occasional multinucleated cells were thought to be conglomerations of sarcolemmal cells. A few acute and chronic inflammatory cells were seen in this area. There were no areas of necrosis; for the most part the process was proliferative. The histological picture was considered characteristic of Weil's disease.

The patient was discharged feeling well on December 29. He was asked to send some rats for study but refused.

Discussion

Only 222 cases of Weil's disease were reported in the United States from 1922 to 1948.[2] Although this is the first case of Weil's disease encountered here, clinical disease resulting from leptospiral infection is being considered with increasing frequency at this hospital.[3] The reason is thought to be an increased awareness on the part of the resident and attending staff of the diverse clinical manifestations of the infections caused by this spirochetal group. Therefore, a brief review of this subject is considered pertinent.

The strains of *Leptospira* causing clinical disease in the United States are principally *Leptospira icterohaemorrhagiae, canicola, Pomona,* and *autumnalis.*[4] These strains vary with respect to their animal host as well as in the clinical picture produced.

The common animal host of *L. icterohaemorrhagiae,* the causative organism of Weil's

disease, is the rat. This organism is present in from 10 to 25% of common adult rats, which are often asymptomatic carriers.[4] The organisms are excreted in rat urine and will live in stagnant water for weeks. Infection is transmitted to man in about 90% of the cases by contact with these waters and in the remainder by direct contact with rats through abrasions in the skin or through the mucous membranes.[5]

Weil's disease occurs most often in individuals whose occupation tends to bring them in contact with infected water—fish cleaners, sewer workers, rice field workers, miners, butchers, and packing house workers. Human-to-human infection has not been reported, although viable organisms are present in the urine of infected patients for weeks or months. By contrast, the usual mode of exposure for canicola fever is close contact with an infected dog, whereas that for Pomona fever is close contact with infected swine or cattle.

CLINICAL DESCRIPTION

The incubation period of infection with *L. icterohaemorrhagiae* is about ten days. For discussion purposes the clinical disease has been divided into three stages.[5] First is the septicemic stage, during which time the organism is circulating in the blood. Usually the disease starts abruptly with fever and chilly sensations and marked muscle aching. Muscular pain and tenderness distinguish the disease at this stage; usually the tenderness is most marked in the calf and paraspinal muscles. Extraocular muscle pain is common so the clinical picture may resemble trichinosis. Gastrointestinal complaints with anorexia, nausea, and vomiting are often present. Cough, occasionally with hemoptysis, is common and this is well explained by radiographic evidence of bronchopneumonia. Conjunctival injection occurs in one-half the cases. In the more severe cases petechiae and ecchymoses are present. Ashe states this is due to capillary toxicosis.[5] In the patient reported, however, thrombocytopenia also could explain the bleeding. Meningeal irritation with a positive Kernig's sign and moderate nuchal rigidity may be present at this stage. Hepatosplenomegaly is uncommon.

Laboratory studies show a leukocytosis with a neutrophilic shift to the left, and oliguria with abnormal urinalysis and azotemia. The almost constant finding of a leukocytosis is in marked contrast to the blood picture usually seen in infectious hepatitis and should alert the clinician to the possibility of Weil's disease. Later jaundice and abnormal hepatic function tests are present. Spinal fluid changes are very common. Cargill and Beeson have called attention to the xanthochromia and pleocytosis present in 86% of their 92 cases.[6] Unfortunately xanthochromic fluid is not confined to this disorder and can occur with marked jaundice regardless of etiology,[7] contrary to many statements in the literature that this fluid is peculiar to the jaundice associated with Weil's disease. Pleocytosis varying up to 3,000 cells, most often mononuclear, is common. Early the predominant cellular type may be polymorphonuclear. Beeson states that 10% of patients presenting with aseptic meningitis have leptospirosis. In a series of 600 specimens submitted with a clinical diagnosis of aseptic meningitis, Broom found 18 cases of Weil's disease.[8b]

The second stage of the clinical disease is arbitrarily chosen as the period of jaundice. Although some patients (probably 50%) never develop icterus, it usually appears about five days after the onset of the illness when the fever has returned towards normal.[5] The patient remains critically ill as he becomes afebrile in contrast to most patients with infectious hepatitis. Oliguria becomes more pronounced. The patient may become semicomatose or delirious. Death occurring in this stage is from either renal or hepatic failure. Unusual complications may be pericarditis, pancreatitis, exanthem, myocarditis, parotitis, and iridocyclitis. Marked anemia is uncommon, in contrast to the case reported here.

Convalescence in the third stage may last from one to eight weeks. During this time relapse may occur, usually between the third and fifth week; most often this is less severe than the initial illness, possibly the favorable result of antibody formation.

Weil's disease often does not present the classical picture described. Some subtle features may escape detection. It may appear as grippe in mild cases, as infectious hepatitis, as aseptic meningitis, or as bronchopneumonia. The presence of any of these features, especially if accompanied by muscle pain, lack of clinical improvement with temperature defervescence, and possible exposure to rats, should alert the clinician to the possibility of this disease so that proper diagnostic procedures will be followed.

The above clinical syndrome described for infections with *L. icterohaemorrhagiae* is very similar to that caused by *L. canicola*, although the latter is most often less severe. *L. Pomona*, however, manifests itself principally as aseptic meningitis without jaundice, renal abnormalities, or gastrointestinal symptoms. Infection with *L. autumnalis* is characterized by a peculiar pretibial rash, splenomegaly, and low fatality, jaundice being rare.[8]

DIAGNOSTIC PROCEDURES

Agglutination studies using antigens of multiple strains of *Leptospira* to measure the serum antibody titer of the patient is presently the most reliable method for diagnosis. Antibodies become positive by the tenth day, and often by the first week, and persist for months or years. Cross reactions to antigens from different strains may occur, but the high titer rise of the homologous type on serial examination is in contrast to the lesser rise in the heterologous type.[9] Two or more tests must be done at time intervals as proof of present infection and to differentiate type specific reaction. A titer of 1:300 is diagnostic of present or past infection.[10]

Uncommonly, the diagnosis may be made early by direct examination of the blood in the first week of illness. This method is difficult and not reliable. After the first week, the organisms in the urine may be demonstrated by inoculation into an experimental animal; the guinea pig is commonly used. White mice less than three weeks old are probably more suitable for this test since they are highly susceptible to leptospiral infection, organisms being identified in the liver and kidney at the time of death of the animal; specific identification may be made by serological studies.[11] The separate strains of *Leptospira* have no morphological differences.[2] The subject's urine must be made neutral or slightly alkaline immediately and injection of the experimental animal performed as soon as possible.

A new test that would be group specific to explore the possibility of any leptospiral infection would be more desirable. The problem is being attacked, incorporating three selected antigens with wide cross reactions using a complement fixation test.[8b] Recently Chang and McComb have isolated a substance from Leptospira called ESS, which is adsorbed on red blood cells and yields hemagglutination with antibodies to all strains.[12] These two procedures, both in the developmental stage, may offer the small laboratory an opportunity to make group specific diagnosis of leptospirosis early in the course of the disease. Another helpful diagnostic procedure has been muscle biopsy, which may confirm the diagnosis before agglutination titers can be returned.[13] Muscle changes have been reported as early as the thirteenth day of illness and persist for some time. The case reported showed typical muscle changes nine weeks after the onset of the illness. The microscopic picture includes a focal involvement in groups of muscle fibers or single muscle fibers with early vacuolization, followed by a loss of cellular detail and subsequent sarcolemmal proliferation. Inflammatory cells are not prominent. Recently Sheldon showed that there is antigen fixation in the sarcoplasm.[14]

THERAPY

The treatment of this disease has been very disappointing. *In vitro* studies showing penicillin and oxytetracycline to be leptospirostatic were not followed by expected *in vivo* benefits. Animals infected with leptospiral organisms were found to be benefited if penicillin, streptomycin, chlortetracycline, or oxytetracycline were administered very early after inoculation; but if a few days elapsed, the animals were not favorably affected. No apparent clinical benefit could be demonstrated by Smadel in 79 patients treated with these agents.[8e] Hall reported similar findings in a group of 67 patients.[15] By contrast, Gsell believes that patients treated early with the tetracyclines do have a favorable clinical response.[8d] He states that patients treated on the first or second day develop no specific organ involvement and a shortened clinical course, and that the patients treated by the fourth day will not develop meningeal involvement. However, administration after the fourth day results in no benefit. Gsell found that in 28 cases treated early, antibody response was suppressed and agglutination titers were lower than in those cases treated later. Since it is rarely possible to treat a case before the fifth day of the illness, a more potent therapeutic agent is highly desired. In the case reported here no beneficial effect from the administration of a combination of penicillin and oxytetracycline was discernible. Cortisone may have had some effect on the hemorrhagic diathesis.

PROGNOSIS

Broom reported a 20% mortality rate in 465 cases, 85% of whom were jaundiced.[8b] In a series from Holland in which only 55% were jaundiced, the mortality rate was only 12%,[8] while Molner's report from Detroit of 78 cases showed a mortality rate of 40%.[2] If the patient survives, complete recovery is the rule.

PATHOLOGY

Pathological changes found at necropsy include variable degrees of degeneration and necrosis in the liver and renal tubular cells as the principal abnormalities. Myocarditis of a minor degree is found, and the lungs often show petechiae with evidence of bronchopneumonia. The brain shows some perivascular infiltration. The changes in the muscles previously described are evident.

Summary

A case of Weil's disease clinically diagnosed and serologically confirmed is presented and the literature regarding leptospirosis in general and Weil's disease in particular is briefly reviewed. This is the first case reported from Wisconsin and the first case diagnosed in Minnesota.

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REFERENCES

1. Larson, C. L.: Weil's disease; report of 51 cases occurring in Puerto Rico and United States, Pub. Health Rep. 56:1650–1656 (Aug. 15) 1941.

2. Molner, J. G., Meyer, K. F., and Raskin, H. A.: Leptospiral infections; survey, J.A.M.A. 136:814–819 (March 20) 1948.

3. Pearson, R. T., and Hall, W. H.: Canicola fever; report of human infection due to leptospira canicola in Minnesota, Minnesota Med. 35:1127–1130 (Dec.) 1952.

4. Gleiser, C. A., Lt. Col., *et al.*: Bulletin of Army Medical Services, Graduate School, Walter Reed Hospital.

5. Ashe, W. F., Pratt–Thomas, H. R., and Kumpe, C. W.: Weil's disease; complete review of American literature and abstract of world literature; 7 case reports, Medicine 20:145–210 (May) 1941.

6. Cargill, W. H., Jr., and Beeson, P. B.: Value of spinal fluid examination as diagnostic procedure in Weil's disease, Ann. Int. Med. 27:396–400 (Sept.) 1947.

7. Nesbitt, S.: Personal communication to the authors.

8. Symposium on Leptospirosis, Army Medical Service Graduate School, Walter Reed Army Medical Center, Med. Sc. Pub. No. 1 (Dec.) 1952.
   (a) Borg–Peterson, C.
   (b) Broom, J. C.
   (c) Gochenour, M. B., Jr.
   (d) Gsell, O.
   (e) Smadel, J. E.
   (f) Yager, R. H., Lt. Col.

9. O'Connell, P. J., and Broom, J. C.: Weil's disease; cautionary tale, Lancet 1:1088–1090 (May 31) 1952.

10. Cowden, F. E., Ownby, F. D., and Isham, R. L.: Weil's disease; report of 4 cases emphasizing 2 adjuncts to early diagnosis, Am. Pract. & Digest Treat. 3:353–360 (May) 1952.

11. Bertucci, E. A., Jr.: Leptospirosis, Am. J. M. Sc. 209:86–111 (Jan.) 1945.

12. Chang, R. S., and McComb, D. E.: Erythrocyte sensitizing substances from five strains of Leptospirae, Am. J. Trop. Med. & Hyg. 3:481–489 (May) 1954.

13. Sheldon, W. H.: Lesions of muscle in spirochetal jaundice (Weil's disease; spirochetosis icterohemorrhagica), Arch. Int. Med. 75:119–124 (Feb.) 1945.

14. Sheldon, W. H.: Leptospiral antigen demonstrated by fluorescent antibody technic in human muscle lesions of *Leptospirosis icterohemorrhagiae,* Proc. Soc. Exper. Biol. & Med. 84:165–167 (Oct.) 1953.

15. Hall, H. E., and others: Evaluation of antibiotic therapy in human leptospirosis, Ann. Int. Med. 35:981–998 (Nov.) 1951.

16. Packchanian, A.: Weil's disease in Georgia: report of nine human cases, J.M.A. Georgia 43:632–634 (July) 1954.

TB ASSOCIATION ANNUAL MEETING SET FOR APRIL 19–20

"Old Battle—New Tactics" is the theme of the 48th annual meeting of the Wisconsin Anti-Tuberculosis Association to be held at the Hotel Schroeder, Milwaukee, April 19–20.

Six major areas in tuberculosis control will be highlighted at the meeting with each topic to be introduced by keynote speakers at the morning and luncheon sessions. The topics will be explored in greater detail at round-table discussions scheduled for the afternoons.

Sessions each day will begin at 10 a.m. and continue through the afternoon. There is no registration fee for the meeting nor for any of the sessions.

For further information, write to: Annual Meeting Committee, Wisconsin Anti-Tuberculosis Association, 1700 W. Wells St., Milwaukee 1.

Comments on Treatment

Editor—HARRY BECKMAN, M. D., Marquette University, Milwaukee

The Placebo

In these days when new drugs are hurtling so rapidly into the armamentarium we must not overlook the effects of emotion on drug action. I do not mean the differences in response to central nervous system-affecting drugs that reflect temperamental differences in patients but rather the actual achievement of desired effects from drugs incapable in themselves of producing such effects. This implies giving a drug with the deliberate intention of playing upon the patient's emotions and is a perfectly legitimate therapeutic procedure because physiologic performances are compounded of many simultaneously acting forces, among which are psychic influences. The astute pharmacologist admits placebos into the armamentarium with which he attempts to serve the practitioner, though he cannot provide a list of such agents since the many intangibles under practical circumstances may justify the transference of any drug into this category. Our remote forefathers had only placebos to dispense, and it is inescapable that the survival of medicine into the scientific era attests their worth.

It is of foremost importance to understand that the placebo is only a means of projecting to the patient that force and healing power which he believes, or at least wants, you to have. You "give" him something and in doing so pass some of this "way-to-recover" over to him. There are still numerous maladies for which there is no scientific or rationally based treatment. Some patients can be told this to their advantage, others cannot; it depends upon the individual's need for emotional support and security. In the case of a person unable without assistance to endure the knowledge that he is in a condition, perhaps not permanently but at least presently, for which there is no specific alleviation, it would be actually cruel to deny the relief obtainable through faith in you and your drug (placebo) given with assurance. Another valuable indication for placebo therapy is a case in which protracted diagnostic procedures are necessary in order to arrive at the true nature of the patient's ailment; unless you "do something"; *i.e.*, give him a drug to take, this patient may refuse further cooperation before the decision is reached that could ultimately be helpful.

The above are really the only two legitimate indications for placebo therapy, except in double-blind testing of new drugs; but there is actually a third type which is probably at the present time used more often than any other. I am referring here to the rush by the patient to demand, and the practitioner to use, each of the latest drugs as their wonder-working powers are announced. Patients believe in them and you may, too, at the time; or you may give them upon demand with tongue in check. This may sometimes turn out to have been placebo therapy, for many of the new drugs simply do not fulfill the early-made claims. But the patient believed in them and so perhaps did you. And you both got results.

Shall we deny to the gods the thanks due for making man the impressionable animal he is? It seems to me that unless the doctor is willing to admit that his role as a dispenser of placebos, whether of drug or other nature, is upon occasion an important part of the doctor–patient relationship, he had better quit dealing with people and go into veterinary medicine.—HARRY BECKMAN, M. D.

INTERNATIONAL ACADEMY OF PROCTOLOGY
8TH ANNUAL TEACHING SEMINAR

Dates: April 23–26, 1956

Place: The Drake, Chicago

Seminar Subject: Anorectal and colon surgery.

All physicians and their wives are invited to attend the seminar, whether or not they are affiliated with the Academy. There is no fee for attendance. The Woman's Auxiliary has planned an unusual program for the wives of the members and their guests.

1956 Annual Meeting Program

The physician who views the exhibit of the U. S. Naval Dental Corps (above) will be challenged to decide how he would handle the various types of injuries which can be simulated on this lifelike manikin. Accepted types of treatment will be demonstrated periodically throughout each day of the Annual Meeting.

Milwaukee Auditorium and Hotel Schroeder
May 1, 2, 3, 1956

The Program

The 1956 Annual Meeting Scientific programs were prepared under the immediate direction of M. G. Rice, M. D., Stevens Point, in cooperation with the Council on Scientific Work of the State Medical Society and representatives of the several sections of the Society and specialty organizations in Wisconsin.

Council on Scientific Work

S. A. MORTON, M. D.
Milwaukee
Chairman

M. G. RICE, M. D.
Stevens Point
Program Chairman

K. E. LEMMER, M D.
Madison
Chairman, Scientific Exhibits

L. G. KINDSCHI, M. D.
Monroe

M. F. HUTH, M. D.
Baraboo

J. Z. BOWERS, M. D.
Madison
Dean, University of Wisconsin
Medical School

J. S. HIRSCHBOECK, M. D.
Milwaukee
Dean, Marquette University
School of Medicine

R. S. BALDWIN, M. D.
Marshfield
Medical Editor, Wisconsin Medical Journal

★ **REGISTRATION:** Secure your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Kilbourn Street. Registration hours: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, hospital personnel and medical assistants, admitted on Thursday, if previously certified, or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND MD'S IN MILITARY SERVICE:** Members of Veterans Administration must be members of the Society to be admitted. Those physicians in armed services admitted by presenting certification of current military service.

★ **TELEPHONE SERVICE:** At Milwaukee Auditorium —During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to BR 3–7250 or BR 3–7251. Calls for Milwaukee doctors should be directed through Physicians Service Bureau (Broadway 1–4131), and they will be transmitted to a staff member of the Medical Society of Milwaukee County in attendance at the Auditorium to receive the calls. At the Hotel Schroeder—Delegates can be reached during sessions of the House by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Broadway 1–7250). Those attending luncheons at the Schroeder Hotel can be reached in the same manner between 12:00–2:00 p.m. If you are attending luncheons, inform your secretary of your schedule, so you can be located promptly if you are to be called. Give your secretary the number or letter of the room where the luncheon will be held.

★ **RESERVATIONS FOR REFRESHER COURSES:** Refresher courses on Tuesday, Wednesday and Thursday, 9:00 to 10:00 a.m., are limited to 40 physicians each. Admittance by ticket only. Make reservations by submitting refresher course reservation blank, page 298. Reservations accepted until maximum is reached. All reservations will be confirmed. Pick up refresher course tickets at registration desk. *Those not picked up by 8:45 a.m. each morning will be released on first come-first served basis.*

★ **RESERVATIONS FOR ANNUAL DINNER:** Reservations for annual dinner (7:00 p.m., Thursday, May 3) may be obtained at registration desk in Milwaukee Auditorium from 8:00 a.m. to 4:00 p.m. each day. Attendance at annual dinner by ticket only. Limit 450. Use reservation form, page 298.

★ **RESERVATIONS FOR GOLF TOURNAMENT:** Contact Mr. A. H. Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee. $10.00 covers all costs including green fees. Tournament will be held at the Brynwood Country Club, 6000 West on Good Hope Road, Milwaukee, on Monday, April 30. Tee-off time, 11:00 a.m. Dinner and presentation of awards, 6:30 p.m.

YOU NEED THESE RESERVATIONS

Refresher Courses

Use reservation card page 298 or write to State Medical Society office indicating first, second and third choice for each course you wish to attend.

Specially Luncheons and Dinners

See noon and evening listings in the program.

Annual Dinner, 7 p.m., Thursday, May 3

Use reservation card page 298 or write to State Medical Society office. Enclose $6.00 per ticket for reservation.

New Member Luncheon, 12 Noon, Wednesday, May 2

All physicians who became new members of the Society since May, 1955, are invited. Special invitation will be sent by Society.

Golf Tournament, Monday, April 30

See above.

Hotel

See page 283.

PROGRAM

TUESDAY, MAY 1
GENERAL PRACTICE DAY

Program sponsored by the Wisconsin Academy of General Practice. Meetings open to all physicians. Application has been made to permit Academy members to qualify for maximum hours of credit in Category I.

8:00 a.m.—Registration Opens, Milwaukee Auditorium

Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—REFRESHER COURSES

(1) "The Maintenance of Health of the Geriatric Patient"

WILLIAM B. KOUNTZ, M.D., *Assistant Clinical Professor of Medicine, Washington University,* St. Louis, Missouri

Juneau Hall (40 physicians—by ticket only)

(2) "Drugs and Malignancy"

HARRY BECKMAN, M.D., Milwaukee

Room 3, Sports Arena (40 physicians — by ticket only)

(3) "The Uses and Abuses of Steroids in Dermatology"

ROBERT KIERLAND, M.D., *Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota,* Rochester, Minnesota

DONALD M. RUCH, M.D., Milwaukee, Moderator

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "Recent Developments in the Diagnosis and Treatment of Poliomyelitis"

RANDOLPH BATSON, M.D., *Associate Professor of Pediatrics, Vanderbilt University,* Nashville, Tennessee

PETER WISNIEWSKI, M.D., Milwaukee

J. C. PETERSON, M.D., Milwaukee, Moderator

Kilbourn Hall—A Panel (40 physicians—by ticket only)

(5) "Lesions of the Anus, Rectum and Colon"

FREDERICK A. COLLER, M.D., *Professor of Surgery, University of Michigan Medical School,* Ann Arbor, Michigan

CARL EBERBACH, M.D., Milwaukee, Moderator

Room 2, Sports Arena (40 physicians — by ticket only)

10:00 a.m.—Recess to View Exhibits

★

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

RAY RICHARDS, M.D., Eau Claire, *President, Wisconsin Academy of General Practice,* Moderator

10:45 a.m.—"Drugs in Relation to Geriatrics of Special Interest to General Practitioners"

WILLIAM B. KOUNTZ, M.D., *Assistant Clinical Professor of Medicine, Washington University,* St. Louis, Missouri

Graduate of Washington University. Director of scientific research for the Gerontological Research Foundation and president of the Gerontological Society. He will discuss the indications for the use of various drugs in gerontology. "The direct use of drugs should be avoided unless there is thorough knowledge of the physiological need and response of the patient."

11:15 a.m.—"Papanicolaou Smears: An Opportunity for Diagnosis for General Practitioners"

WILLIAM D. STOVALL, M.D., Madison

★

Tuesday Noon

12:00 noon—Wisconsin Dermatological Society Luncheon (members only)

Milwaukee Athletic Club

Reservations through Donald Ruch, M.D., 208 E. Wisconsin, Milwaukee

Paper presented by Robert R. Kierland, M.D.

Tuesday Afternoon

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

ROBERT F. PURTELL, M.D., Milwaukee, *President-Elect, Wisconsin Academy of General Practice,* Moderator

2:00 p.m.—"What's New and What's True in What's New in Dermatology"

HERBERT RATTNER, M.D., *Professor and Chairman, Department of Dermatology and Syphilology, Northwestern University School of Medicine,* Chicago, Illinois

Native of Chicago, now chief editor of the A.M.A. Archives of Dermatology. He will consider new concepts with respect to the cause of itching; status of steroid therapy; advances in mycology; the use of antimalarial drugs for skin diseases; and the treatment of acne scars by dermabrasion.

2:30 p.m.—"Acute Hepatitis in Infancy and Childhood"

RANDOLPH BATSON, M.D., *Associate Professor of Pediatrics, Vanderbilt University,* Nashville, Tennessee

Native of Mississippi. Graduate of Vanderbilt University School of Medicine. Currently director of Vanderbilt Poliomyelitis Respiratory Center. Interested in polio principally from the standpoint of respiratory physiology and management.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Surgery of the Gallbladder and the Bile Ducts"

FREDERICK COLLER, M.D., *Professor of Surgery, University of Michigan Medical School,* Ann Arbor, Michigan

A native of South Dakota and a graduate of the Harvard Medical School in 1912. Internship and residency at Massachusetts General Hospital. Following service in World War I, he came to the University of Michigan. He is a past-president and regent of the American College of Surgeons and a past-president of the American Surgical Association.

[New Delegates' Meeting at 4:00 p.m., Parlor A, Schroeder Hotel]

4:15 p.m.—"Visible Tumor Clinic" (Kodachromes)

STURE A. M. JOHNSON, M.D., Madison, Moderator

ROBERT KIERLAND, M.D., *Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota,* Rochester, Minnesota

Note: This unusual presentation of visible tumors, both benign and malignant, will be made with Kodachromes. History and photomicrographs of biopsies will be presented along with a panel discussion on differential diagnosis and treatment. Emphasis will be placed on clinical appearance and its implications in establishing the diagnostic procedures that might be employed.

HARRY R. FOERSTER, M.D., Milwaukee

DAVID KERSTING, M.D., Milwaukee

Doctor Kierland

Graduate of University of Minnesota Medical School. Special consultant, U.S.P.H.S.; member of Editorial Board of Journal for Investigative Dermatology. Will discuss the benign lesions which may be confused with malignant and pre-malignant lesions. Emphasizes the cutaneous signs by which underlying malignant disease may be recognized.

Opening Day Is General Practice Day

Tuesday Evening

5:15 p.m.—Delegates' Buffet Dinner (delegates only)

Pere Marquette Room, Schroeder Hotel

6:00 p.m.—American Academy of Pediatrics Dinner (members only)

Reservations through Karl Beck, M.D., 1411 Wauwatosa, Wauwatosa

Paper presented by Randolph Batson, M.D.

6:30 p.m.—House of Delegates, First Session

East Room, Schroeder Hotel

At this session, the reports of all officers and committees are presented. President-Elect, L. O. Simenstad, M.D., Osceola, will address the House and announce committee appointments for the ensuing year. A nominating committee is selected and new committee reports and new business considered and referred to the appropriate reference committees.

8:30 p.m.—Gemütlichkeit Night

Ballroom, Schroeder Hotel

All Society members and their wives are invited to an informal evening of entertainment. Talent, both professional and intraprofessional, will be featured. Come. Stay as long as you like.

HOTEL ACCOMMODATIONS FOR ANNUAL MEETING IN MILWAUKEE

Name of Hotel	*Single*	*Double*	*Twin Beds*
Medford	$4.50 to $ 5.25	$6.25 to $ 7.00	$ 8.50 to $10.00
Pfister	$5.00 to $ 9.00	$7.50 to $10.00	$ 8.00 to $12.00
Plankinton House	$5.50 to $10.00	$8.00 to $11.00	$ 9.00 to $15.00
*Schroeder	$5.00 to $ 8.00	$8.00 to $12.00	$10.00 to $16.00
Wisconsin	$4.50 to $ 8.00	$6.75 to $10.00	$10.00 to $11.50

* Headquarters hotel for Annual Meeting.

All rates listed above are for rooms with bath. Rates subject to change. Information about suites and large capacity rooms available on request.

HOTEL RESERVATION

State Medical Society of Wisconsin Annual Meeting—Milwaukee, May 1–2–3, 1956

Mail Direct to Hotel of First Choice

Hotel—First Choice: _____; Second: _____; Third: _____

Please reserve the following type room for me starting _____
Day Date

Single _____ Double _____ Twin Beds _____ (all with bath)

Please confirm this reservation to:

PRINT NAME: _____

ADDRESS: _____
Street City

WEDNESDAY, MAY 2

8:00 a.m.—Registration Opens, Milwaukee Auditorium
Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—Reference Committees of House of Delegates

9:00 a.m.—REFRESHER COURSES

(1) "Prolonged Labor"

WILLIAM MENGERT, M.D., *Professor of Obstetrics and Gynecology, University of Illinois College of Medicine,* Chicago, Illinois

CARLTON WIRTHWEIN, M.D., Milwaukee, Moderator

Kilbourn Hall (40 physicians—by ticket only)

(2) "Management of Benign and Malignant Lesions of the Breast"

GRANTLEY W. TAYLOR, M.D., *Assistant Clinical Professor of Surgery, Harvard Medical School,* Boston, Massachusetts

JAMES CONLEY, M.D., Milwaukee, Moderator

Juneau Hall (40 physicians—by ticket only)

(3) "Office Ophthalmology"

PETER DUEHR, M.D., Madison

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "Emergency Treatment of Hand Injuries"

FRANK D. BERNARD, D.D.S., M.D., Madison

Room 2, Sports Arena (40 physicians — by ticket only)

(5) "How to Handle the Newer Antibiotics in Pulmonary Lesions"

ELWOOD W. MASON, M.D., Milwaukee

Room 3, Sports Arena (40 physicians — by ticket only)

(6) "Contrast Examination of the Cardiovascular System"

M. M. FIGLEY, M.D., *Assistant Professor, Department of Radiology, University of Michigan Hospital,* Ann Arbor, Michigan

Room 4, Sports Arena (40 physicians — by ticket only)

10:00 a.m.—Recess to View Exhibits

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

MAURICE G. RICE, M.D., *General Program Chairman, Council on Scientific Work,* Moderator

10:30 a.m.—"Aids in the Diagnosis of Liver Disease"

EDWARD A. GALL, M.D., *Professor of Pathology, University of Cincinnati, College of Medicine,* Cincinnati, Ohio

Native of New York City. Graduate of Tulane University Medical School. Secretary of the American Association of Pathologists and Bacteriologists and currently director of laboratories, Cincinnati General Hospital. He has made significant contributions and investigations with regard to malignant lymphoma, pathogenesis of carcinoma, hepatitic disorders, and effects of radiation.

11:00 a.m.—"Gynecological Office Procedures"

JOHN E. FABER, M.D., *Sections of Obstetrics and Gynecology, Mayo Clinic,* Rochester, Minnesota

11:30 a.m.—"Malignant Melanoma"

GRANTLEY W. TAYLOR, M.D., *Assistant Clinical Professor of Surgery, Harvard Medical School,* Boston, Massachusetts

This lecture is sponsored by the Milwaukee and Wisconsin Divisions of the American Cancer Society. Native of New Jersey. Graduate of Harvard University Medical School. This paper is an end result study of 360 cases of malignant melanoma. Analysis will clarify the indications for regional dissections, the incidence of node metastases for various primary sites, and the adequacy and efficacy of standard regional dissections when nodes are involved. It appraises possible benefits from ultra radical and en bloc surgical procedures.

Act Now!! Get Refresher Course Reservations

Wednesday Noon

12:00 noon—New Member Luncheon
East Room, Schroeder Hotel

12:00 noon—Clinic Managers Luncheon
Parlor A, Schroeder Hotel

12:00 noon—Wisconsin Society of Pathologists Luncheon
Club Rooms, Schroeder Hotel

Open to all interested physicians.

"Some Pathological Features of Obstructive and Viral Hepatitis," Edward A. Gall, M.D., Cincinnati.

Reservations through Robert S. Haukohl, M.D., 1821 W. Wisconsin, Milwaukee

12:30 p.m.—Wisconsin Surgical Society Luncheon (members only)
Pere Marquette Room, Schroeder Hotel

Reservations through J. M. Sullivan, M.D., 161 W. Wisconsin, Milwaukee

★

Wednesday Afternoon

SPECIAL PROGRAM ON SURGERY

JUNEAU HALL, MILWAUKEE AUDITORIUM

Planned in cooperation with the Wisconsin Surgical Society but open to all members of the State Medical Society.

S. B. Gundersen, M.D., La Crosse, *President, Wisconsin Surgical Society,* Moderator

2:00 p.m.—Presidential Address
"Cocktails, Canapes and Colic"
Thomas J. Snodgrass, M.D., Janesville

2:30 p.m.—"Diagnosis and Treatment of Occlusive Femoral Artery Disease"
James E. Conley, M.D., Milwaukee

2:40 p.m.—"Experiences with Pancreatic Tumors"
Sigurd B. Gundersen, Jr., M.D., La Crosse

3:00 p.m.—Recess to View Exhibits

3:15 p.m.—"Pulmonary Resection for Metastatic Lesions of the Lungs"
Joseph W. Gale, M.D., Madison

3:35 p.m.—"Problems in the Surgical Management of Duodenal Ulcer"
C. Sherrill Rife, M.D., Milwaukee

4:00 p.m.—Business Meeting (members only)

SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY

KILBOURN HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Society of Obstetrics and Gynecology but open to all members of the State Medical Society.

Dean D. Willson, M.D., Fond du Lac, *President, Wisconsin Society of Obstetrics and Gynecology,* Moderator

2:00 p.m.—A Panel:

"Hypofibrinogenemia"
George Hank, M.D., Madison

"Induced Labor in Modern Obstetrics"
L. H. Verch, M.D., Milwaukee

"Uterine Rupture"
Leo Grinney, M.D., Racine

"Transfusions in Modern Obstetrics"
T. J. Rice, M.D., Marshfield

Doctor Mengert and Doctor Faber will discuss the above presentations.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Highlights of Female Genital Cancer"

William Mengert, M.D., *Professor of Obstetrics and Gynecology, University of Illinois College of Medicine,* Chicago, Illinois

Native of Washington, D. C., and graduate of Johns Hopkins Medical School. He was professor and chairman of the Department of Obstetrics and Gynecology at the Southwestern Medical School of the University of Texas from 1943 until 1945. He has held various offices including that of general program chairman of the American Congress on Obstetrics and Gynecology and was chairman of the Test Committee in Obstetrics and Gynecology of the National Board of Medical Examiners from 1953 until 1955.

New Members: Come To Special Program Wednesday

SPECIAL PROGRAM ON RADIOLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Radiological Society but open to all members of the State Medical Society.

R. W. BYRNE, M.D., Milwaukee, Moderator

2:00 p.m.—"Radiologic Evaluation of Mitral Valve Disease"

M. M. FIGLEY, M.D., *Assistant Professor, Department of Radiology, University of Michigan Hospital,* Ann Arbor, Michigan

A native of Ohio and a graduate of the Harvard Medical School in 1944. Internship and residency at University Hospitals of Cleveland. After 23 months with the U. S. Army, he received an appointment at the University of Michigan. In 1953, he was awarded the 5-year Markle Scholarship in Medical Science.

2:30 p.m.—"Pathologically Proven Mediastinal Masses"

J. G. BULGRIN, *Captain, MC, USN,* Great Lakes, Illinois

A native of Illinois and a graduate of the University of Wisconsin in 1935. He entered the Medical Corps, U. S. Navy, in 1937 and has been on active duty continuously since that date. The chief interest in his presentation is the roentgen–pathologic correlation of common diseases in the young adult age group and demonstration of some vagaries of common diseases, as well as highly unusual lesions.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Tumors of the Chest in Infants and Children"

HANS HEFKE, M.D., Milwaukee

4:05 p.m.—"Pyelovenous Backflow in Excretory Urology"

GENE SENGPIEL, M.D., Milwaukee

★

Wednesday Evening

6:00 p.m.—Wisconsin Surgical Society Dinner (members only)

University Club

Reservations through J. M. Sullivan, M.D., 161 W. Wisconsin, Milwaukee

"Keeping Abreast with the Breast Controversy," Grantley Taylor, M.D.

6:00 p.m.—Wisconsin Society of Obstetrics and Gynecology Dinner (members only)

Milwaukee Athletic Club

Reservations through W. V. Luetke, M.D., 1023 Regent, Madison

Paper presented by John Faber, M.D.

6:00 p.m.—Wisconsin Radiological Society Dinner (members only)

University Club

Reservations through R. W. Byrne, M.D., 3321 N. Maryland, Milwaukee

Paper presented by M. M. Figley, M.D.

7:30 p.m.—House of Delegates

East Room, Schroeder Hotel

This is the second session of the House of Delegates. Reference committees will begin reporting their recommendations on the reports of officers, standing committees, resolutions and amendments to the Constitution and By-Laws. New business may again be introduced.

All members of the Society are invited to attend.

An Invitation

One of the important functions of the Annual Meeting of the State Medical Society of Wisconsin is the conduct of the House of Delegates. At the first session of the House on Tuesday evening the reports of the officers and committees will be presented along with new business. On Wednesday morning at 8:30 the reference committees will meet at the Schroeder Hotel. Room assignments will be announced. It is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this very important aspect of Society affairs.

THURSDAY, MAY 3

8:00 a.m.—Registration Opens, Milwaukee Auditorium

Scientific Exhibits Open, Milwaukee Auditorium

8:30 a.m.—House of Delegates

East Room, Schroeder Hotel

9:00 a.m.—REFRESHER COURSES

(1) "Emergency Treatment of Head Injuries"—A Panel:

HARRY MAXWELL, M.D., Milwaukee, Moderator

HENRY SUCKLE, M.D., Madison

RAY QUADE, M.D., Neenah

Room 4, Sports Arena (40 physicians — by ticket only)

(2) "Recognition and Treatment of Toxic Psychoses"

VERNON KINROSS-WRIGHT, M.D., *Anderson Department of Psychiatry, Baylor University College of Medicine,* Houston, Texas

JAMES CAFFREY, M.D., Milwaukee, Moderator

Room 2, Sports Arena (40 physicians — by ticket only)

(3) "Hematuria"

MILTON COPLAN, M.D., *Clinical Professor, Division of Urology, Department of Surgery, University of Miami School of Medicine,* Miami, Florida

N. W. BOURNE, M.D., Milwaukee, Moderator

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "The Use of Depressant Drugs"

STUART CULLEN, M.D., *Professor of Surgery and Chairman of Division on Anesthesiology, State University of Iowa, University Hospitals,* Iowa City, Iowa

MILTON DAVIS, JR., M.D., Madison, Moderator

Walker Hall (40 physicians—by ticket only)

(5) "The Tonsil and Adenoid Problem"

JOHN R. LINDSAY, M.D., *Professor and Chief of Otolaryngology, University of Chicago School of Medicine,* Chicago, Illinois

Room 3, Sports Arena (40 physicians — by ticket only)

(6) "The Problems of Peptic Ulcer"

JOSEPH KIRSNER, M.D., Ph.D., *Professor of Medicine, University of Chicago School of Medicine,* Chicago, Illinois

JOSEPH SHAIKEN, M.D., Milwaukee, Moderator

Juneau Hall (40 physicians—by ticket only)

★

SPECIAL PROGRAM ON INTERNAL MEDICINE

KILBOURN HALL, MILWAUKEE AUDITORIUM

Planned in cooperation with the Wisconsin Society of Internal Medicine but open to all members of the State Medical Society. *No advance reservations required.*

MAURICE HARDGROVE, M.D., Milwaukee, *President, Wisconsin Society of Internal Medicine,* Moderator

9:00 a.m.—"Auricular Fibrillation and Nodular Goiter"

BEATRICE BERTEAU, M.D., Milwaukee

(Sponsored by Drs. W. W. Engstrom and G. A. Hellmuth, Milwaukee)

9:20 a.m.—"Studies of Hemolytic Anemia Utilizing Radio-Chromium Labeled Red Cells"

LEE SCHLOESSER, M.D., Madison

(Sponsored by Drs. R. F. Schilling and J. L. Sims, Madison)

9:40 a.m.—"Diagnostic Kidney Biopsy Using the Vim–Silverman Needle"

WALTER H. THIEDE, M.D., Milwaukee

(Sponsored by Dr. J. J. Levin, Wood)

10:00 a.m.—Recess to View Exhibits

Don't Forget Tickets For Refresher Courses

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

S. A. Morton, M.D., Milwaukee, *Chairman, Council on Scientific Work,* Moderator

10:30 a.m.—"The Prevention of Rheumatic Fever —General Principles and Methods"

Gene Stollerman, M.D., *Assistant Professor of Medicine, Northwestern University School of Medicine,* Chicago, Illinois

This presentation is a Lucy Droessel Memorial Lecture of the Wisconsin Heart Association. Doctor Stollerman is a native of New York City; graduate of Columbia Medical School. He is principal investigator at the Sackett Foundation for Research in Rheumatic Fever and Allied Diseases. He recently prepared an audio-visual lecture for the American Heart Association on rheumatic fever. He is the author of the chapter on rheumatic fever in "Holt Pediatrics."

11:00 a.m.—"Ureteral and Bladder Injuries Following Pelvic and Colon Surgery"

Milton Coplan, M.D., *Clinical Professor, Division of Urology, Department of Surgery, University of Miami School of Medicine,* Miami, Florida

Graduate of Vanderbilt University Medical School. Former president of the staff of Jackson Memorial Hospital. Early contributor to research on urinary calculus disease and contributor of the first article on the "loop" catheter for extracting small calculi from the lower segment of the ureter. His paper will discuss management of 30 injuries including diagnosis for surgical correction.

11:30 a.m.—"The Uses and Limitations of the Newer Drugs in the Treatment of Nervous Conditions"

Vernon Kinross-Wright, M.D., *Anderson Department of Psychiatry, Baylor University College of Medicine,* Houston, Texas

This is a Rogers Memorial Lecture presented by Rogers Memorial Sanitarium, Oconomowoc.

A native of England and a graduate of London University in 1944. He received postgraduate training in psychiatry in various hospitals in England before receiving appointments in the psychiatric field in North Carolina starting in 1949. His paper discusses chlorpromazine, Rauwolfia deviations, Miltown, Equanil and other centrally acting drugs which appear to have a wide application in medicine. He points out a variety of unusual side effects which may be overlooked.

Thursday Noon

12:00 noon—Past Presidents' Luncheon
Parlor G, Schroeder Hotel

12:00 noon—Section on Ophthalmology & Otolaryngology Luncheon (members only)
East Room, Schroeder Hotel
Reservations through State Medical Society, Box 1109, Madison 1
Business meeting at 1:15 p.m., followed by open scientific program (see page 290).

12:00 noon—Wisconsin Urological Society Luncheon (members only)
Parlor A, Schroeder Hotel
Reservations through A. P. Graham, M.D., 117 W. Doty, Neenah

12:30 p.m.—Wisconsin Society of Internal Medicine Luncheon (members only)
Pere Marquette Room, Schroeder Hotel
Reservations through Mr. James Eiff, Suite 700, 208 E. Wisconsin Ave., Milwaukee 2

Now Is The Time To Order Annual Dinner Tickets

Thursday Afternoon

SPECIAL PROGRAM OF SECTION ON MEDICAL HISTORY

SOUTH ROOM, SCHROEDER HOTEL

Open to all interested physicians

WILLIAM D. STOVALL, M.D., Madison, Chairman, Presiding

2:00 p.m.—"Pioneer Leadership in Wisconsin Medicine"

MILLARD TUFTS, M.D., Milwaukee

Doctor Tufts will also present an exhibit of the papers of Ira Manley, M.D., Markesan, the 35th President of the State Medical Society, and Nicholas Senn, M.D., Milwaukee, who were close personal friends.

2:40 p.m.—"History with a Feminine Touch"

MRS. J. J. BOERSMA, Green Bay, *President, Woman's Auxiliary to the State Medical Society of Wisconsin*

3:00 p.m.—"The Doctor and Patient in Satire"
A series of Kodachromes

G. KASTEN TALLMADGE, M.D., Milwaukee, *Professor of the History of Medicine, Marquette University*

3:30 p.m.—Comments by the Chairman
"The Development of Medical Education in Wisconsin"

W. D. STOVALL, M.D., Madison

4:00 p.m.—Business Meeting

YOU ARE INVITED TO JOIN

Wisconsin's rich medical heritage can best be preserved through the efforts of physicians and their wives working together with the Section on Medical History and the State Historical Society.

Your support and interest are needed to create a medical museum for Wisconsin; to collect valuable documents, diaries, letters, daybooks, equipment and other papers and artifacts; and to support the preparation of manuscripts recording medical history in the state.

You may join the Section on Medical History (dues $5.00 annually) by writing to the State Medical Society, Box 1109, Madison 1.

SPECIAL PROGRAM ON INTERNAL MEDICINE

JUNEAU HALL, MILWAUKEE AUDITORIUM

Open to all members of the State Medical Society

MAURICE HARDGROVE, M.D., Milwaukee, *President, Wisconsin Society of Internal Medicine,* Moderator

1:40 p.m.—"Microprotein in Rheumatic Fever"
J. R. HEERSMA, M.D., Marshfield

2:00 p.m.—"The Relationship of Group "A" Streptococcal Infections to the Natural History of Rheumatic Heart Disease"

GENE H. STOLLERMAN, M.D., *Assistant Professor of Medicine, Northwestern University School of Medicine,* Chicago, Illinois

2:30 p.m.—"The Place of Cardiac Catheterization in the Diagnosis of Valvular Heart Disease"

JOHN HUSTON, M.D., Milwaukee

2:50 p.m.—Discussion Period

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"The Management of Chronic Ulcerative Colitis"

JOSEPH B. KIRSNER, M.D., Ph.D., *Professor of Medicine, University of Chicago School of Medicine,* Chicago, Illinois

Native of Massachusetts and graduate of Tufts Medical College. President of the American Gastroscopic Society from 1949 to 1950. His paper will point out that management of ulcerative colitis remains symptomatic, individualized and prolonged. Medical treatment is indicated in 85 per cent of cases. He will discuss the use of antibiotics, hormones, diet and the indications for surgical treatment.

4:15 p.m.—"The Management of Acute Renal Insufficiency"

EARL SCHULZ, M.D., Milwaukee

4:40 p.m.—Round Table on "Coronary Disease"

CHESTER KURTZ, M.D., Madison
LESLIE KINDSCHI, M.D., Monroe
M. C. F. LINDERT, M.D., Milwaukee
T. O. NUZUM, M.D., Janesville
R. D. TAYLOR, M.D., Marshfield, Moderator

Join The Section On Medical History — Thursday

SPECIAL PROGRAM ON ANESTHESIA

KILBOURN HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Society of Anesthesiologists but open to all members of the State Medical Society.

MILTON DAVIS, JR., M.D., Madison, Moderator

2:00 p.m.—"Fundamental Errors in Anesthesia"
STUART CULLEN, M.D., *Professor of Surgery and Chairman of Division on Anesthesiology, State University of Iowa. University Hospitals,* Iowa City, Iowa

Graduate of the University of Wisconsin Medical School. Now a director of the American Board of Anesthesiology and associate editor of *Anesthesiology*. He will discuss the peculiar properties of depressant drugs, a means of applying them rationally and safely, and some of the hazards associated with their use. He will also discuss narcotic antagonists.

2:30 p.m.—"Respiratory Emergencies"
JOSEPH J. BUCKLEY, M.D., *Instructor, Department of Anesthesiology, University of Minnesota Medical School,* Minneapolis, Minnesota

Graduate of New York Medical College. He has been chief of the Section on Anesthesiology at the Veterans Hospital, Minneapolis, and is currently a consultant. A concise etiological outline of all types of respiratory emergencies will be presented. Emphasis will be placed upon accurate, rapid diagnosis. The basic physiologic disturbance associated with each problem will be discussed and the appropriate resuscitative measures will be outlined.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Anesthesia in Relation to Cesarean Section"
STUART CULLEN, M.D., Iowa City
GEORGE HANK, M.D., Madison
JOSEPH J. BUCKLEY, M.D., Minneapolis
L. G. KILPATRICK, M.D., Madison, Moderator

SPECIAL PROGRAM OF THE SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

EAST ROOM, SCHROEDER HOTEL

Prepared in cooperation with the Section on Ophthalmology and Otolaryngology but open to all members of the State Medical Society.

HERBERT G. SCHMIDT, M.D., Milwaukee, Presiding

2:15 p.m.—"Surgery of Intraocular Bodies"
CLEMENS KIRCHGEORG, M.D., Neenah

2:45 p.m.—(Topic to be announced)
ALSON E. BRALEY, M.D., *Professor of Ophthalmology, University of Iowa,* Iowa City, Iowa

3:30 p.m.—"The Operation for Stapes Mobilization"
JOHN R. LINDSAY, M.D., *Professor of Otolaryngology, University of Chicago School of Medicine,* Chicago, Illinois

★

SPECIAL PROGRAM ON UROLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

Planned in cooperation with the Wisconsin Urological Society but open to all members of the State Medical Society.

JAMES J. KING, M.D., Milwaukee, *President, Wisconsin Urological Society,* Moderator

2:00 p.m.—"Localization of the Ectopic Ureteral Orifice"
A. M. SONNELAND, M.D., Madison

2:15 p.m.—"The Weak Bladder in Women"
BENJAMIN H. BRUNKOW, M.D., Monroe

2:30 p.m.—"The Effects of Hyaluronidase on Bladder Calculus Formation in Rats"
JOHN W. KEARNS, M.D., Milwaukee

2:45 p.m.—"Experiences With Radical Retropubic Prostatectomy"
H. W. CHRISTENSEN, M.D., Wausau

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—Pyelogram Clinic
WALTER KEARNS, M.D., Milwaukee, Moderator

4:45 p.m.—Business Meeting (for members only)

Be Sure To Send For Refresher Course Reservations

Thursday Evening

5:30 p.m.—President's Reception
East Room, Schroeder Hotel

All Society members and their ladies are invited to the reception for Dr. and Mrs. Ervin L. Bernhart. The reception will honor the conclusion of Doctor Bernhart's term as president of the State Medical Society.

6:00 p.m.—Wisconsin Society of Anesthesiologists Dinner (members only)
Medford Hotel
Reservations through George Kreuter, M.D., 5705 Oakhill Ave., Wauwatosa 13

6:00 p.m.—Wisconsin Urological Society Dinner (members only)
(Place to be announced)
Reservations through James King, M.D., Milwaukee

7:00 p.m.—Annual Dinner
Ballroom, Schroeder Hotel

The social highlight of the Annual Meeting honors physicians who have completed a half century of medical practice and receive engraved certificates attesting their membership in the 50 Year Club. The president-elect, Dr. L. O. Simenstad of Osceola, speaks briefly in assuming the presidency of the Society. The dinner concludes with an outstanding presentation of professional talent.

Hosts For Guest Speakers

The following physicians will serve as hosts for our guest speakers during their visit with us in Milwaukee

Guest	Host
RANDOLPH BATSON	J. C. PETERSON
A. E. BRALEY	DONALD HUGHSON
JOSEPH J. BUCKLEY	JOHN W. TEMPLE
J. G. BULGRIN	S. A. MORTON
FREDERICK COLLER	CARL EBERBACH
MILTON COPLAN	N. W. BOURNE and SIDNEY HURWITZ
STUART C. CULLEN	J. W. BOOKHAMER
JOHN E. FABER	L. T. SERVIS
M. M. FIGLEY	R. W. BYRNE
EDWARD A. GALL	JOSEPH F. KUZMA
ROBERT R. KIERLAND	DONALD M. RUCH
VERNON KINROSS–WRIGHT	JAMES CAFFREY
JOSEPH B. KIRSNER	JOSEPH SHAIKEN
WILLIAM B. KOUNTZ	VALORUS LANG
JOHN R. LINDSAY	HUBERT G. SCHMIDT
WILLIAM MENGERT	ROLAND S. CRON
HERBERT RATTNER	HARRY FOERSTER
GENE H. STOLLERMAN	LAMONT SCHWEIGER
GRANTLEY W. TAYLOR	JAMES CONLEY

Timetable Summary

TUESDAY, MAY 1—GENERAL PRACTICE DAY

8:00 a.m. Registration and Exhibits Open

9:00 a.m. Refresher Courses

10:45 a.m. General Program

12:00 Noon Wisconsin Dermatological Society Luncheon

2:00 p.m. General Program

5:15 p.m. Delegates' Buffet Dinner (delegates only)

6:00 p.m. American Academy of Pediatrics Dinner (members only)

6:30 p.m. House of Delegates, First Session

8:30 p.m. Gemütlichkeit Night

WEDNESDAY, MAY 2

8:00 a.m. Registration and Exhibits Open

9:00 a.m. Reference Committees, House of Delegates

9:00 a.m. Refresher Courses

10:30 a.m. General Program

12:00 Noon New Member Luncheon
Clinic Managers Luncheon
Wisconsin Society of Pathologists Luncheon (open to all interested physicians)

12:30 p.m. Wisconsin Surgical Society Luncheon (members only)

2:00 p.m. Special Program on Surgery
Special Program on Obstetrics and Gynecology
Special Program on Radiology

6:00 p.m. Wisconsin Surgical Society Dinner (members only)
Wisconsin Society of Obstetrics and Gynecology Dinner (members only)
Wisconsin Radiological Society Dinner (members only)

7:30 p.m. House of Delegates, Second Session

THURSDAY, MAY 3

8:00 a.m. Registration and Exhibits Open

8:30 a.m. House of Delegates

9:00 a.m. Refresher Courses
Special Program on Internal Medicine

10:30 a.m. General Program

12:00 Noon Past Presidents' Luncheon
Section on Ophthalmology & Otolaryngology Luncheon (members only)
Wisconsin Urological Society Luncheon (members only)

12:30 p.m. Wisconsin Society of Internal Medicine Luncheon (members only)

1:40 p.m. Special Program on Internal Medicine

2:00 p.m. Special Program of Section on Medical History (open to all interested physicians)
Special Program on Anesthesia
Special Program on Urology

2:15 p.m. Special Program of the Section on Ophthalmology and Otolaryngology

5:30 p.m. President's Reception

6:00 p.m. Wisconsin Society of Anesthesiologists Dinner (members only)
Wisconsin Urological Society Dinner (members only)

7:00 p.m. Annual Dinner

Roster of Distinguished Guest Speakers

ANNUAL MEETING, MAY 1-2-3

O. RANDOLPH BATSON, M. D.	Associate Professor of Pediatrics, Vanderbilt University, Nashville, Tennessee
A. E. BRALEY, M. D.	Professor of Ophthalmology, Department of Ophthalmology, State University of Iowa, Iowa City, Iowa
JOSEPH J. BUCKLEY, M. D.	Instructor, Department of Anesthesiology, University of Minnesota Medical School, Minneapolis, Minnesota
CAPTAIN J. G. BULGRIN	U. S. Naval Hospital, Great Lakes, Illinois
FREDERICK COLLER, M. D.	Professor of Surgery, University of Michigan Medical School, Ann Arbor, Michigan
MILTON COPLAN, M. D.	Clinical Professor, Division of Urology, University of Miami School of Medicine, Miami, Florida
STUART C. CULLEN, M. D.	Professor of Surgery and Chairman of Division on Anesthesiology, State University of Iowa, University Hospitals, Iowa City, Iowa
JOHN E. FABER, M. D.	Section of Obstetrics and Gynecology, Mayo Clinic, Rochester, Minnesota
M. M. FIGLEY, M. D.	Assistant Professor, Department of Radiology, University of Michigan Hospital, Ann Arbor, Michigan
EDWARD A. GALL, M. D.	Professor of Pathology, University of Cincinnati College of Medicine, Cincinnati, Ohio
ROBERT R. KIERLAND, M. D.	Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota
VERNON KINROSS-WRIGHT, M. D.	Anderson Department of Psychiatry, Baylor University College of Medicine, Houston, Texas
JOSEPH B. KIRSNER, M. D., Ph. D.	Professor of Medicine, University of Chicago School of Medicine, Chicago, Illinois
WILLIAM B. KOUNTZ, M. D.	Assistant Clinical Professor of Medicine, Washington University, St. Louis, Missouri
JOHN R. LINDSAY, M. D.	Professor of Otolaryngology, University of Chicago School of Medicine, Chicago, Illinois
WILLIAM MENGERT, M. D.	Professor of Obstetrics and Gynecology, University of Illinois College of Medicine, Chicago, Illinois
HERBERT RATTNER, M. D.	Professor and Chairman, Department of Dermatology and Syphilology, Northwestern University School of Medicine, Chicago, Illinois
GENE H. STOLLERMAN, M. D.	Assistant Professor of Medicine, Northwestern University School of Medicine, Chicago, Illinois
GRANTLEY W. TAYLOR, M. D.	Assistant Clinical Professor of Surgery, Harvard Medical School, Boston, Massachusetts

Plan To Attend and Hear These Speakers!

SCIENTIFIC

EXHIBITS

Wisconsin Physicians and Medical Groups Present a Visual Education Program

The Council on Scientific Work through Dr. Kenneth Lemmer is pleased to present the following scientific exhibits as a part of the Annual Meeting program, May 1–2–3. Physicians are urged to utilize recess periods and other free time for review of the material provided through the cooperation of the various individuals and agencies listed:

1. NON-TUBERCULOUS CHEST DISEASES

Veterans Administration Hospital, Madison, Wisconsin, (B. C. Taylor, M. D.)

This exhibit will consist of five panels, each representing a case history which will depict hospital care, x-rays, pre- and postoperative (if surgery is performed) and gross and microscopic pathology sections. The diagnosis will be given at the bottom of the panel, revealed by pushing a button to light up the diagnosis. Make your own diagnosis and see how you score.

2. (a) KINESCOPE DISPLAY

Wisconsin Division, American Cancer Society

This will show professional films available through the American Cancer Society suitable for showing at hospital staff conferences, county medical society meetings, etc.

2. (b) MILWAUKEE CANCER DIAGNOSTIC CLINIC, INC.

Milwaukee Division, American Cancer Society

The theme of this display will be to point out the results of diagnostic studies in 1500 cases examined. This will be presented against a background of information as to how the Clinic operates.

X-rays, artist drawings of gastroscopic and proctoscopic views, gross and microscopic pathologic slides will be arranged to highlight the clinical information pertaining to CA of the Breast, CA of the Stomach, CA of the Cervix, CA of the Colon and Rectum, and malignant polyps.

3. STAFF OF COLUMBIA HOSPITAL, MILWAUKEE

This exhibit will set forth some of the teaching and investigational activities of the staff.

4. ELECTIVE PLASTIC SURGERY OF THE FACE

Frank D. Bernard, D. D. S., M. D., Madison, Wisconsin

This exhibit will include surgical treatment of congenital and acquired deformities of the face.

5. (Title in Final Program)

Milwaukee Hospital Clinical Staff

6. TUMORS OF THE SMALL INTESTINE

Marquette University School of Medicine (Drs. J. F. Kuzma and Leo R. Weinshel)

This exhibit will show the experience with small bowel tumors which were encountered over the course of many years. The clinical-pathological correlation of the tumors is to be made. It is planned to have fourteen by seventeen translight clinical data correlated with gross and microscopic colored transparencies of the lesions.

7. ACUTE CHOLECYSTITIS: SIGNS AND SYMPTOMS, PATHOLOGY AND TREATMENT

Marquette University and Milwaukee County Hospital (Dr. David W. Barrow, Milwaukee)

8. CARDIOVASCULAR SURGICAL TECHNIQUE—"OPEN" CARDIAC SURGERY

St. Luke's Hospital, Milwaukee (Henry F. Twelmeyer, M. D.)

A simple oxygenator and pump devised to bypass the heart for open cardiac surgery will be illustrated. This is based on the equipment developed at the University of Minnesota.

9. NEUROSURGICAL DIAGNOSIS AND TREATMENT OF BRAIN TUMORS

St. Luke's Hospital, Milwaukee (Drs. J. D. Levin, W. J. Blake and C. E. Schmidt, and Mr. Adam Tomes)

This exhibit will consist of documentation of eight cases of brain tumors treated at St. Luke's Hospital. It will include clinical histories, x-rays, E.E.G.'s microphotographs and angiograms.

10. LATEST DEVELOPMENTS IN UPPER EXTREMITY PROSTHETICS

E. C. Welsh, M. D., Columbia Hospital, Milwaukee, and Henry Okagaki, M. D., University of Wisconsin Medical School, Madison

This will consist of a demonstration showing the proper fitting of prosthetics and upper extremity amputations. In addition to the sponsoring physicians there will be certified limb makers and physical therapists who will assist in the demonstration. The demonstrations will be held only during the recess periods in the morning and afternoon.

11. ARTHRITIS REGISTRATION AND ARTHRITIS EXPOSED

Wisconsin Chapter, Arthritis and Rheumatism Foundation, Milwaukee

This exhibit will describe the activities and services of the Arthritis Foundation with special emphasis on the Arthritis Registration Program and the availability of the book "ARTHRITIS EXPOSED." It will also touch on services of the Physical Therapy Mobile Unit in Milwaukee and the plans for clinics and research in cooperation with the University of Wisconsin and Marquette University Medical Schools.

12. THE MULTIPLE ROLE OF THE MODERN TB HOSPITAL

Wisconsin Anti-Tuberculosis Association, Milwaukee

The modern sanatorium for the treatment of tuberculosis aims to be a hospital. Wisconsin physicians have used these facilities for the isolation and treatment of this infectious disease. Therapy in the last nine years has included the use of drugs and resectional surgery. Immediate results have been excellent.

The State Medical Society through its Division on Tuberculosis and Chest Diseases also has endorsed the sanatorium as a place to educate the patient with tuberculosis. The patient must be taught a proper mode of life. He must learn to protect others from this infection. The sanatorium with its modern x-ray equipment ond bacteriological culture laboratory, under competent medical direction, can well aid the practicing physician in the diagnosis and treatment of his tuberculous patient. These and other roles of the sanatorium have helped develop it as a modern TB hospital.

13. PREVENTIVE MEASURES IN THE MANAGEMENT OF HEMIPLEGIA

Ray Piaskoski, M. D., Veterans Administration Hospital, Wood

This exhibit illustrates by means of photographs various physical medicine procedures employed in preventing the common deformities frequently associated with hemiplegia. These deformities are usually the result of improper body positioning, prolonged bed rest, and spastic muscle groups. The exhibit is divided into three sections dealing wth the bed phase, wheel chair phase, and ambulatory phase. Various simple, easily made devices as well as physical treatments are illustrated. Most of the program shown can be easily employed in the management of hemiplegics at home or in smaller hospitals where trained therapists are not available.

14. NEUROLOGY SERVICE IN A GENERAL HOSPITAL

Drs. Max Primakow, E. A Niles, B. S. Schaeffer, and Francis J. Millen, Veterans Administration Hospital, Wood

15. SURGICAL ANATOMY IN PULMONARY RESECTIONS

Drs. Wilson Weisel, Raymond R. Watson, Derwood Lepley, Howard L. Kuhl, and Donald P. Davis, Veterans Administration Hospital, Wood

This exhibit, having to do with the surgical anatomy encountered in resections of the lung, is designed to present accurate paintings originally sketched at the operating table. In addition special injected specimens of lungs have been prepared so that they may be handled and viewed at close range for careful determination of the detailed hilar and sub-hilar surgical anatomy of the lung.

16. GROSS TISSUE DEMONSTRATIONS

Section on Pathology and the Wisconsin Society of Pathologists

Fixed and fresh gross pathological specimens will be demonstrated by various pathologists.

17. LUMBAR SYMPATHECTOMY

Henry M. Suckle, M. D., Madison

This exhibit is designed to demonstrate the aims, the contraindications and results of lumbar sympathectomy. The major diagnostic points providing indications for the operative procedure are not only listed, but also illustrated. Lumbar sympathetic block as a diagnostic measure is fully illustrated and the operative procedure of lumbar sympathectomy with anatomical and surgical drawings is fully illustrated.

18. THE PREVENTION OF RHEUMATIC FEVER

Wisconsin Heart Association, Milwaukee

This exhibit will serve as an adjunct to the main Wisconsin Heart Association exhibit on research which will be presented at the 1956 meeting of the State Medical Society of Wisconsin. Among other things, the prevention exhibit shows in enlarged form the bacteria, hemolytic streptococci, as it appears on a sheep blood agar plate. Also of interest will be the presentation of a simplified office method of checking cultures for beta hemolytic streptococcus.

19. BLOOD VESSEL GRAFTS

Milwaukee County Medical Society and Veterans Administration Hospital, Wood, Wisconsin (Drs. James M. Sullivan, Milwaukee, James Conley, Milwaukee, and Ned Maxwell, M.lwaukee)

This exhibit will be in three sections. The first section will illustrate the organization, procurement and processing involved in obtaining blood vessel grafts and there will be a demonstration of freeze-drying equipment. The second section will give the indications and objectives in blood vessel grafting plus methods of diagnosis. The third section will give illustrative cases in which blood vessel grafts may be used.

19a. HISTOPLASMOSIS DETECTED AMONG ROUTINE CHEST CLINIC REFERRALS

Beloit Health Department (J. C. Springberg, M. D., Health Commissioner)

A review of unusual cases of histoplasmosis encountered in a community health program, which illustrates the productive results of routine chest clinic referrals.

20. BLOOD DERIVATIVES THROUGH THE RED CROSS BLOOD PROGRAM

Badger Regional Blood Center, Madison (Merle Owen Hamel, M. D.)

This display presents material on blood derivatives available through the Red Cross Blood Program, with specimens of the products and pictures of their uses. Included are fresh frozen plasma, red cell mass, serum albumin, gamma globulin, and fibrinogen.

21. U. S. NAVAL DENTAL CORPS CASUALTY TREATMENT TRAINING PROGRAM

Dental Division, Bureau of Medicine and Surgery, Department of the Navy

This exhibit illustrates various phases of the casualty treatment training program for naval dental officers.

Featured in the exhibit are some of the training aids developed by the Naval Dental School at Bethesda, Maryland, to develop skill and dexterity in treating casualties. One outstanding feature is a model of a military casualty fitted wth several types of moulages simulating different injuries. The viewer is challenged to decide how he would handle the injuries. When the exhibit is displayed, the accepted type of emergency treatment is demonstrated at appropriate intervals.

22. FOREIGN BODIES IN THE EYE

Jackson Clinic, Madison (Everet H. Wood, M. D.)

This exhibit will consist of a simulated ophthalmic treatment office, with treatment chair, treatment table, light and a display of the necessary instruments for taking care of foreign bodies of the eye. Exhibit will be illustrated by various plaques containing pictures of eyes with foreign bodies, methods of getting these foreign bodies in the eye, illustrations of treatment, x-rays of intraocular foreign bodies, and some illustrations of the disastrous results which may occur if the foreign body is poorly treated. These illustrations will be explained by appropriate printed matter adjacent to the pictures.

SPECIAL EDUCATIONAL EXHIBITS IN FIFTH STREET FOYER ADJACENT TO MEETING HALLS

OPPORTUNITIES IN THE U. S. PUBLIC HEALTH SERVICE

U. S. Public Health and State Board of Health

This exhibit describes briefly the role of the Public Health Service in the areas of clinical medicine, research, and preventive health services. It utilizes opportunities for careers in the Public Health Service or for professional service in national emergencies.

THE MENTALLY RETARDED CHILD, HIS PHYSICIAN AND HIS SCHOOL

State of Milwaukee Health Department

This exhibit outlines services to mentally retarded children developed in the Milwaukee school system. The material would be of great interest to general practitioners who are encountering more and more frequently problems in connection with retarded children brought to them by parents.

SERVICES TO THE BLIND

Division of Public Assistance, State Department of Public Welfare

This exhibit will consist of representative equipment used by the blind or used for instruction of the blind together with descriptive leaflets and selected photographs of blind workers. It will include Braille writing equipment, specially adapted measurement devices, optical aids for subnormal vision, a Talking Book machine and records. Leaflets will describe services in detail.

AMERICAN PHYSICAL THERAPY ASSOCIATION

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

This exhibit will explain one of the most recent organizations to be established in the paramedical field. The Medical Assistants Society seeks to create a group of persons with like interests who can use the society as a means for self-improvement, assistance to the medical profession in the field of public relations, and various social activities. It seeks to enlist the support of physicians in having their medical assistants join the society. The exhibit will explain the purposes of the society and several projects which the group sponsors in support of its goals.

Things To Remember

Make up a party for Gemutlichkeit Night, Tuesday, May 1 . . . refreshments "on the house."

★

Don't miss the Visible Tumor Clinic at 4:15 p.m., Tuesday, May 1. First of its kind anywhere.

★

These specialty programs are open to all members of the Society:

Surgery—Wednesday

Obstetrics and Gynecology—Wednesday

Radiology—Wednesday

Pathology—Wednesday

Internal Medicine—Thursday

Ophthalmology and Otolaryngology —Thursday

Anesthesia—Thursday

Urology—Thursday

★

Be sure to attend at least one session of the House of Delegates: Tuesday or Wednesday evening, and Thursday morning.

★

An unusual program on Medical History is scheduled for 2 p.m., Thursday, May 3.

★

Send in your reservation for refresher courses and annual dinner —right now!

Don't Miss Gemütlichkeit Night

HOTEL SCHROEDER, TUESDAY, MAY 1, AT 8:30 P. M.

CRYSTAL BALLROOM

Fun!!! No Cover Charge Fun!!!

Dancing . . . Music . . . Floor Show

An entirely new innovation climaxes General Practice Day at the 1956 Annual Meeting. Dancing to Steve Swedish and his Orchestra in the Crystal Ballroom.

The Ballroom will be set up in "nite club" style with continuous music, dancing and entertainment. Adding to the festivities will be the talents of Wisconsin physicians and Auxiliary members whose novelty numbers will be interspersed with presentations by professional entertainers.

BE SURE TO ATTEND . . . NO COVER CHARGE . . . FUN GALORE

Summary Of Refresher Courses

(Admission by Ticket Only—Use Reservation Form Next Page)

Tuesday, May 1—General Practice Day

1. "THE MAINTENANCE OF HEALTH OF THE GERIATRIC PATIENT"
   William B. Kountz, M. D., St. Louis
2. "DRUGS AND MALIGNANCY"
   Harry Beckman, M. D., Milwaukee
3. "THE USES AND ABUSES OF STEROIDS IN DERMATOLOGY"
   Robert Kierland, M. D., Rochester
   Donald M. Ruch, M. D., Milwaukee, Moderator
4. "RECENT DEVELOPMENTS IN THE DIAGNOSIS AND TREATMENT OF POLIOMYELITIS"
   Randolph Batson, M. D., Nashville
   Peter Wisniewski, M. D., Milwaukee
   J. C. Peterson, M. D., Milwaukee, Moderator
5. "LESIONS OF THE ANUS, RECTUM AND COLON"
   Frederick A. Coller, M. D., Ann Arbor
   Carl Eberbach, M. D., Milwaukee, Moderator

★

Wednesday, May 2

1. "PROLONGED LABOR"
   William Mengert, M. D., Chicago
   Carlton Wirthwein, M. D., Milwaukee, Moderator
2. "MANAGEMENT OF BENIGN AND MALIGNANT LESIONS OF THE BREAST"
   Grantley W. Taylor, M. D., Boston
   James Conley, M. D., Milwaukee, Moderator
3. "OFFICE OPHTHALMOLOGY"
   Peter Duehr, M. D., Madison
4. "EMERGENCY TREATMENT OF HAND INJURIES"
   Frank D. Bernard, D.D.S., M. D., Madison
5. "HOW TO HANDLE THE NEWER ANTIBIOTICS IN PULMONARY LESIONS"
   Elwood W. Mason, M. D., Milwaukee
6. "CONTRAST EXAMINATION OF THE CARDIOVASCULAR SYSTEM"
   M. M. Figley, M. D., Ann Arbor

★

Thursday, May 3

1. "EMERGENCY TREATMENT OF HEAD INJURIES"—A Panel:
   Harry Maxwell, M. D., Milwaukee, Moderator
   Henry Suckle, M. D., Madison
   Ray Quade, M. D., Neenah
2. "RECOGNITION AND TREATMENT OF TOXIC PSYCHOSES"
   Vernon Kinross-Wright, M. D., Houston
   James Caffrey, M. D., Milwaukee, Moderator
3. "HEMATURIA"
   Milton Coplan, M. D., Miami
   N. W. Bourne, M. D., Milwaukee, Moderator
4. "THE USE OF DEPRESSANT DRUGS"
   Stuart Cullen, M. D, Iowa City
   Milton Davis, Jr., M. D., Madison, Moderator
5. "THE TONSIL AND ADENOID PROBLEM"
   John R. Lindsay, M. D., Chicago
6. "THE PROBLEMS OF PEPTIC ULCER"
   Joseph Kirsner, M. D., Ph.D., Chicago
   Joseph Shaiken, M. D., Milwaukee, Moderator

Annual Dinner

HOTEL SCHROEDER, THURSDAY, MAY 3, 7:00 P. M.

PRESENTATION OF GAVEL: The official badge of office is presented by incoming president L. O. Simenstad to President Ervin L. Bernhart as a token of his service.

HONORS TO NEW MEMBERS OF "50 YEAR CLUB": The following members will be granted certificates and pins as newly qualified members of the Club in recognition of a half century of medical practice:

R. G. ARVESON, M. D.---Frederic
FREDERICK BAUER, M. D.---Shawano
FRANK O. BRUNCKHORST, M. D.---Neenah
VIRGIL D. CRONE, M. D.---Beloit
CHARLES FIDLER, M. D.---Milwaukee
A. A. HOYER, M. D.---Beaver Dam
J. F. McNARY, M. D.---Milwaukee
WILL G. MERRILL, M. D.---Ashland
DANIEL F. NAUTH, M. D.---Kiel
ROLLAND G. RAYMOND, M. D.---Brownsville
JOSEPH F. ROSE, M. D.---Lena
FREDERICK W. SEEGERS, M. D.---Milwaukee
PAUL C. WAGNER, M. D.---Milwaukee

FLOOR SHOW: Professional entertainment of unusually high caliber will be presented immediately following the short ceremonies above. There will be two hours of fine music, dancing, singing, acrobatics and variety talent. The program will conclude at 10:00 p. m.

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1956 Auxiliary Convention Program

Tuesday, May 1

P.M.

4:00 Registration, Fifth Floor, Hotel Schroeder

MRS. BOERSMA

Those who attend: State Officers, State Chairmen, County Presidents and Presidents-Elect, Past State Presidents and Honored Guests.

(Dress, semiformal)

6:30 Board of Directors' Dinner, English Room, Hotel Schroeder

8:30 Gemütlichkeit Night, Ballroom, Hotel Schroeder

Wednesday, May 2

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

10:00 Formal Opening of the Twenty-Eighth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

Mrs. J. J. Boersma, President, presiding

Invocation—Dr. Thomas Lyter, Pastor, Washington Park Presbyterian Church, Milwaukee

Acceptance of Agenda

Pledge to Flag—Mrs. J. G. Jamieson, Racine

Pledge of Loyalty—Mrs. J. G. Jamieson, Racine

Introduction of Officers and Honored Guests

Address of Welcome

Response—Mrs. R. T. Schmidt, Green Bay

Convention Announcements—Mrs. G. A. Behnke, Kaukauna

Convention Rules of Order—Mrs. M. J. Reuter, Milwaukee

Roll Call—Mrs. D. L. Williams, Madison

Minutes of Twenty-Seventh Meeting—Mrs. D. L. Williams, Madison

Address of President—Mrs. J. J. Boersma

Reports of County Presidents (Time limit—2 minutes)

Report on Registration—Mrs. W. S. Giffin, Appleton

P.M.

12:00 Coffee Break

12:30 Meeting reconvenes

. . . Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

2:30 May Day Salad Luncheon and Fashion Show Gimbels' Main Dining Room

MRS. FLANDERS

. . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

7:00 Buffet Supper, Crystal Ballroom, Hotel Schroeder

In honor of Mrs. Robert Flanders, Manchester, N. H., President-Elect, Woman's Auxiliary to the American Medical Association

Thursday, May 3

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

10:00 Business Session, Crystal Ballroom, Hotel Schroeder

Mrs. J. J. Boersma, President, presiding

Convention Announcements—Mrs. G. A. Behnke

Memorial Service—Mrs. J. W. Boren, Jr., Marinette

Report of Nominating Committee — Mrs. V. S. Falk, Edgerton

Election of Officers

Installation of Officers—Mrs. Robert Flanders

Presentation of President's Pin

Inaugural Address—Mrs. H. W. Christensen, Wausau

Final Report on Registration—Mrs. W. S. Giffin

11:30 Post-Convention Board Meeting, Crysta Ballroom, Hotel Schroeder

Mrs. H. W. Christensen, President, presiding

P.M.

1:00 Luncheon, Crystal Ballroom, Hotel Schroeder
In honor of County Presidents of 1955–56 and a salute to the newly organized Wood and Lincoln County auxiliaries

Mrs. H. W. Christensen, President, presiding

A Message from National—Mrs. Robert Flanders, President-Elect, Woman's Auxiliary to the American Medical Association

Public Relations for Volunteer Service Organizations

Mrs. Jessie Cartwright, Home Service Director, Norge Division of Borg–Warner Company

. . . Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Hotel Schroeder

MRS. CHRISTENSEN

6:30 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

Convention Hostesses

WOMAN'S AUXILIARY TO THE OUTAGAMIE COUNTY MEDICAL SOCIETY

Front row, left to right: Mrs. F. M. Hauch, Mrs. M. S. Kagen, Mrs. Robert DeCock.

Second row, left to right: Mrs. H. T. Gross, Mrs. W. S. Giffin, Mrs. E. J. Zeiss, Mrs. G. A. Behnke, Mrs. L. B. McBain.

Third row, left to right: Mrs. E. F. Mielke, Mrs. W. J. Frawley, Mrs. F. S. Marshall, Mrs. D. W. Curtin.

PHOTO DATA. CAMERA: 4X5 VIEW CAMERA; EXPOSURE: 1/25 SEC. AT F.11 EXISTING LIGHTING.

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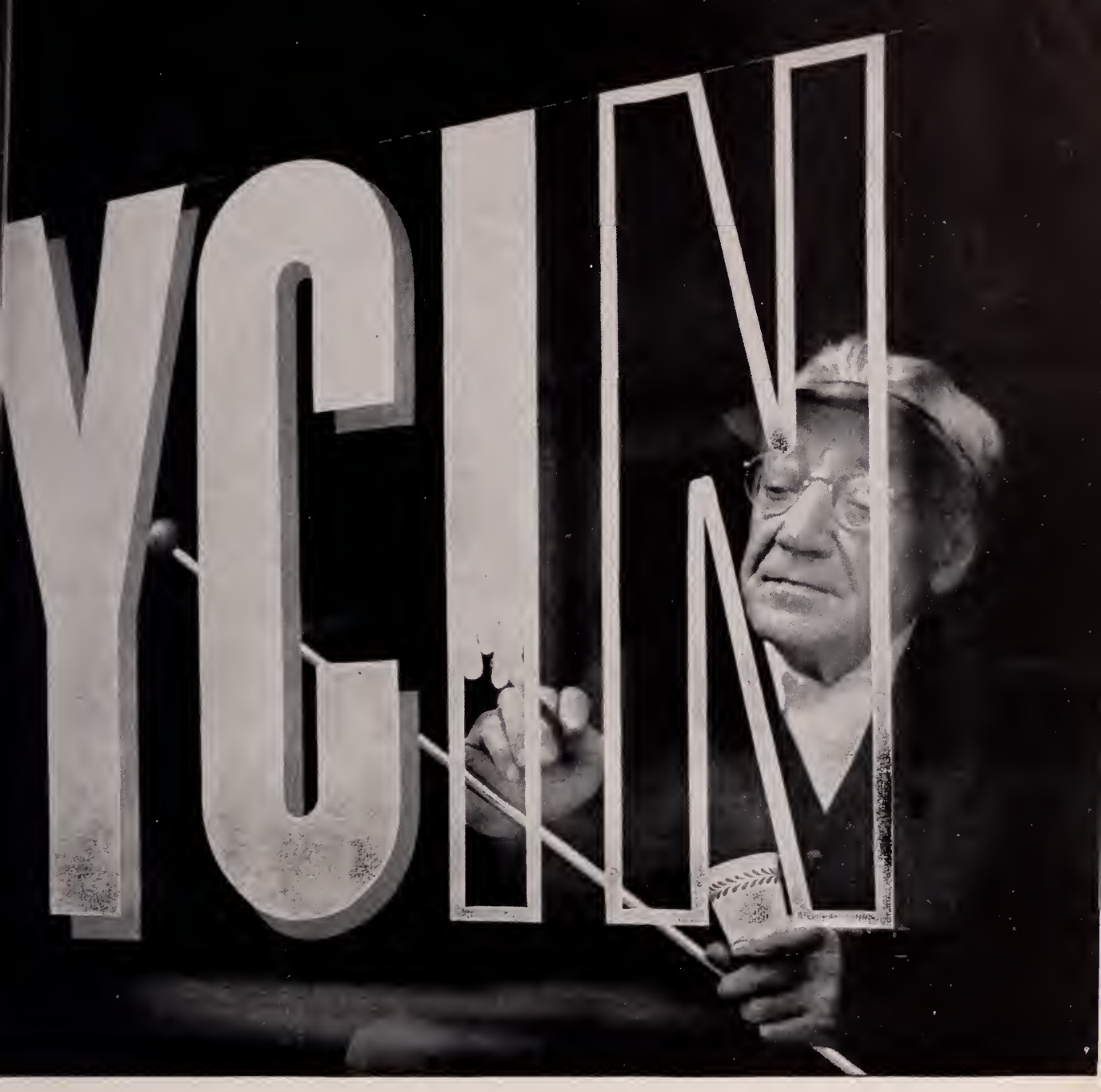

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The Failure of Testosterone Lotion to Aggravate Acne Vulgaris in Teen-age Males

By A. A. HOLBROOK, M. D.
Milwaukee

ANDROGENS are generally considered to be an important factor in acnegenesis, although the mechanism involved has yet to be fully elucidated. Since topical estrogen therapy has been shown to improve some acne eruptions, it seemed pertinent to explore the effects of androgen applied in similar fashion. Accordingly, a testosterone lotion,* as closely comparable to "Premarin" lotion* as the solubilities of the respective steroids would permit, was prepared. The testosterone content was set at 10 mg. per cc. since experience[1] has suggested that this concentration matches antagonistically the 1 mg. of conjugated equine estrogens per cc. of "Premarin" lotion.

The Study

On Acne Cases Being Treated With "Premarin" Lotion: In 1951–1952 a study[2] using "Premarin" tablets and cream was conducted on 17 cases of acne at the Milwaukee Country Day School. In 1953 an additional series of 19 cases using "Premarin" lotion was studied. Six reliable boys were selected from the second group to start a pilot study with the testosterone lotion.

The "Premarin" lotion was discontinued for two weeks. It is interesting to note that the skin in each case was observed to have remained static during that interval. The androgen lotion was then applied to the previously treated areas in similar dosages as to frequency and amount. Over a 14-day period no skin changes attributable to the testosterone could be discovered. The occasional acneform lesion which appeared was considered well within the expected range for the individual case. In no instance was an exacerbation produced.

The negative results in this small study raised questions as to whether the effects of the estrogen lotion were still present and whether the doses of androgen were large enough. In an attempt to find the answers, the final project was initiated six months later.

On Cases Not on "Premarin" Lotion Therapy: Twelve boys between the ages of 15 and 18 were selected primarily on the basis of their reliability and cooperative spirit. They all shared a definite tendency to develop acne vulgaris, though at the time only minimal evidence was present. None had had estrogen in any form or any other dermatologic treatment for at least seven months. In fact, only three of them had ever had estrogenic therapy. Each volunteer was given a 4 oz. bottle of the testosterone lotion and a small cylindrical vial. He was instructed to carry the latter well filled in his pocket at all times and to apply the lotion liberally with his finger tips every waking hour or two. The sites designated were the forehead, cheek, and chin on just one side of the face; the other side was used as a control.

The experiment was continued for 16 days. The boys were 100% regular in their daily use of the lotion, the number of applications per subject varying between seven and eight a day. Each boy was formally examined at the onset, after the first week, and at the end of the therapy, as well as at casual intervals between times. At the conclusion of the experiment a comparison of how the skin appeared before and after treatment and a comparison of the treated and control sides of the face showed no change in any case. The androgen lotion did not increase local oiliness, formation of comedones, or the production of acne lesions. No systemic effects were noted.

Comment

The literature of the past 15 years by and large supports James B. Hamilton's[3] statement made in 1941 "that testosterone propionate . . . is able to produce an acneform reaction in suspectible subjects if present in the body fluids and tissues in sufficiently

* Supplied by Ayerst Laboratories, New York City.

high and sustained concentrations." Each of the 12 boys in the series had already had acne vulgaris in varying degrees; hence, they were categorically considered "susceptible subjects."

The efficacy of a local application of estrogens as a means of building up sufficient concentration of the hormone in the skin seems to be beyond question. Numerous investigators would testify to the success of this technique. Widespread experience with another group of hormones of the cortisone family, similarly employed, further confirms the point.

It is also pertinent to call attention to the local effects of certain vitamins applied to the skin. Schreiner *et al.*[4] have worked with pyridoxine in cases of seborrheic dermatitis of the "sicca" type and reported that "the treated lesions cleared within 5–21 days." Finally, Flesch[5] has demonstrated marked local improvement in some patients with ichthyosis anointed with 3% vitamin A ointment. The control areas showed no change. He emphasized that this benefit probably represented a nonspecific drug effect and not the restitution of a vitamin A deficiency.

The possibility of the duration of the experiment being too short to provoke an acne response in the skin naturally arises. However, in experience with the topical administration of estrogen in more than 50 cases of acne, those responding to the therapy usually demonstrated some change within one or two weeks of conscientious treatment. Analogously, therefore, 16 days is considered a sufficiently "sustained" period for the androgen to produce acne.

Conclusion

Testosterone lotion (10 mg. per cc.) applied adequately to the faces of a dozen teenage males susceptible to acne vulgaris failed to cause any apparent skin changes.

425 East Wisconsin Avenue.

REFERENCES

1. Jewell, John B.: Personal communication to the author.
2. Holbrook, A. A.: Treatment of acne vulgaris in teen-age males with oral and topical administration of estrogenic hormone, Wisconsin M. J. 52:425–428 (Aug.) 1953.
3. Hamilton, J. B.: Male hormone substance; prime factor in acne, J. Clin. Endocrinol. 1:570–592 (July) 1941.
4. Schreiner, A. W., Rockwell, E. M., and Vilter, R. W.: Local defect in metabolism of pyridoxine in skin of persons with seborrheic dermatitis of "sicca" type, J. Invest. Dermat. 19:95–96 (Aug.) 1952.
5. Flesch, Peter: Inhibition of keratin formation with unsaturated compounds, J. Invest. Dermat. 19:353–363 (Nov.) 1952.

WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Milwaukee, Sunday, April 29, 1956

Registration—1:30 P.M., Foyer, Fifth Floor

Scientific Program—2:00 P.M., East Room, Fifth Floor

SCIENTIFIC PROGRAM

1. "Recent Advances in the Management of Asthma"
   G. A. Koelsche, M. D., Mayo Clinic, Rochester, Minnesota
2. "Pulmonary Manifestations of Collagen Diseases"
   Joseph F. Kuzma, M. D., Milwaukee, Wisconsin
3. "Atrial Fibrillation—Reversion to Sinus Rhythm"
   Ray W. Kissane, M. D., Columbus, Ohio
4. "The Significance of Isolated Nodular Lesions in the Chest X-ray"
   Edwin R. Levine, M. D., Chicago, Illinois
5. "The Treatment of Congestive Heart Failure"
   John F. Briggs, M. D., St. Paul, Minnesota
6. Panel Discussion of Questions from the Audience—
   Moderator: Mischa J. Lustok, M. D., Milwaukee, Wisconsin
   Participants: G. A. Koelsche, M. D., Joseph F. Kuzma, M. D., Ray W. Kissane, M. D., Edwin R. Levine, M. D., John F. Briggs, M. D.

Employee Health Services

As It Looks to Your State Board of Health

EMPLOYEE health services provided by industry complement private medical services in maintaining the health of individual employees. Complete employee health services involve much more than emergency care of accidents or illness occurring on the job and should be a program of positive health maintenance under the supervision of a physician.

Basic to the employees' well-being is a safe and healthful work environment. This requires careful joint planning by medical, safety, and personnel departments. It would include consideration of the materials and processes used in the plant as well as observance of laws and health regulations.

A major aspect of the preventive program is that of supervision of the health status of the individual through examination, counseling, and proper job placement. This can be most effectively done by a physician who knows the industry and the conditions under which the employees work. Most plants do require a more or less complete preplacement physical examination. Ideally, the examinations include an evaluation of the prospective worker's physical fitness as related to the specific tasks he will be called on to perform. The examining physician is encouraged to communicate with the employee's personal physician regarding even minor abnormalities noted.

After the worker is on the job, periodic health maintenance examinations may be called for, their frequency depending on the type of industry and his particular job. Another examination that may be indicated is one performed when the employee returns to work following prolonged illness or absence due to other cause. A terminal physical examination may also be advisable when the worker leaves the plant. All of these examinations should be sufficiently complete as judged by the examining physician to protect the health not only of the individual being examined but also of fellow workers and the public. When conditions requiring correction are found, the worker is then referred to a physician of his own choice.

Another part of health maintenance is the planning and carrying out of a program of health education in cooperation with the industrial nurse and other staff members, if any. Other services designed to maintain and improve health and well-being of workers would be determined by the kind and size of industry, health hazards present, etc.

A medical director, full or part-time or on a consultation basis, is needed in all plants to provide medical direction for the industrial nurse. This includes providing well-formulated, written, signed, standard procedures. These procedures serve as authorization for approved routine care of minor injuries and illnesses and are a directive for emergency care of more serious conditions until the services of a physician can be obtained.

These, then, are key points in any in-plant health service. Detailed responsibilities of the physician who is a medical director and the industrial nurse will vary from plant to plant depending upon the type of industry and the personalities involved. Many other aspects of in-plant medical services might be mentioned such as the relationship of the medical staff to management, to other physicians in the area, to professional organizations and governmental agencies. The reference below discusses these things in more detail than can be done in this short article.[1]

So much for in-plant health services in general. Do Wisconsin industries provide them for their employees? The answer is not an unqualified "yes," but it is encouraging. We do have over 350 industrial nursing services in the state. While there are not nearly as many medical directors on a full or part-time or consulting basis, the number is constantly increasing. Many more plants could benefit from a planned program under the direction of a physician. Assistance is available from the State Board of Health to help in planning such health services and to aid in the control of occupational diseases.

—ALLAN FILEK, M. D., *Director, Section on Local Health Administration.*

REFERENCE

1. Industrial Health, a guide for medical and nursing personnel, Industrial Health Committee, State Medical Society of Wisconsin, and Industrial Hygiene Division, State Board of Health.

THE MEDICAL FORUM

ASK "GO-SLOW" POLICY ON SOCIAL SECURITY CHANGES

Council OKs Original Intent of Benefit Law, Opposes New Amendment

Madison—A resolution, urging a "go-slow" policy in Social Security legislation, won unanimous endorsement of the Council of the State Medical Society Feb. 26.

The Council made it clear it favored Social Security in its original intent—to provide a basic pension for workers taxed by the program, and survivorship benefits for families of such workers.

In its resolution, the Council considered *only* proposed new amendments *(HR 7225)* due to come before the U. S. Senate this spring. The amendments have been described by actuarial authorities and others as *"actuarially unsound, definitely regimentation and politically-devised."*

MURPHY ACTIVE

Atty. Robert B. L. Murphy, Madison, Society counsel, appeared against the amendments at a U. S. Senate Finance Committee hearing in Washington Feb. 23. He also appeared before the Council, explaining his testimony before the lawmakers.

The Council voted to send its action on the resolution to Wisconsin members of the House of Representatives, which passed the amendments in a quick push last year, and the Senate.

INTEREST CENTERED

The Council based its testimony mainly on two phases of the amendments, the liberalizations of disability benefits and the unsound financing involved.

In regard to the disability phases of the amendments, the resolution objected to:

1. Establishment of a disability insurance system for persons 50 and over without due consideration of the size and extent of the problem;

2. The estimate of experts in rehabilitation and retraining that up to 97 per cent of all handicapped persons can be rehabilitated to the extent of gainful employment;

LACKS SAFEGUARDS

3. Implications for the social security program of grafting a cash disability system of unknown, but unquestionably very large proportions, onto the rehabilitation program.

4. A requirement that physicians certify disability under the unrealistic definition contained in a section of the bill, which is totally deficient in safeguards and reference points which reduce abuse in other fields of compensable injuries.

COST MONUMENTAL

In addition, the resolution decries the *"astronomical cost of the disability insurance, which the chief actuary of the Social Security Administration estimates will add an average of not less than two billion dollars per year to the cost of that system."*

The resolution urges withholding passage of the amendments until such time as Congress completes a **full, impartial study** of the social security system *"as it now exists, the direction which it is taking and the costs of the system, however it is to be continued."*

MATCHES NATIONAL DEBT

Mr. Murphy said the amendments would not be sound because Social Security, to date, **"has had terrifying unsound financing, with a current liability of 280 billion**

(Continued on page 313)

Dr. Arveson Renamed Council Chairman

Madison—Dr. R. G. Arveson of Frederic, a past president of the State Medical Society, was reelected Chairman of its Council at a meeting here Feb. 26.

Dr. F. L. Weston, Madison, was renamed treasurer and Charles H. Crownhart, Madison, secretary.

Other officers named:

Dr. H. Kent Tenney and Dr. N. A. Hill, of Madison, assistant treasurers; Dr. R. S. Baldwin, Marshfield, medical editor of *The Wisconsin Medical Journal,* and Dr. J. M. Sullivan, Milwaukee, editorial director of the *Journal.*

Dr. Hill also was reelected trustee of the S.M.S. Realty Corp.

OK Rate Hike for Michigan Blue Cross

Lansing, Mich.—A Michigan Hospital Service (Blue Cross) request for a 23 per cent rate increase has been rejected, Joseph A Navarre, Commissioner of Insurance, reported in late February.

A 15 per cent boost was granted, after a second proposal was submitted.

The initial fee increase request encounted stern opposition from Walter P. Reuther, president of the International Union, UAW–CIO. He said the proposed 23 per cent hike *"would definitely place the cost of hospitalization insurance outside the means of a great number of people in Michigan . . . and especially hard hit will be retired workers and those who do not have employer contributions."*

CARRIED HERE

(Reuther's letter to Navarre, protesting the initial boost, was printed in the **Medical Forum** of the **Wisconsin Medical Journal** in January.)

Gov. G. Mennen Williams announced plans to appoint a special commission to study voluntary prepaid hospital and medical plans, specifically Blue Cross–Blue Shield in Michigan.)

FIRST IN A SERIES: DOCTOR'S ROLE IN ADOPTIONS

Give Varied Assistance In Placement Programs

Madison—You cannot underestimate the role of the M. D. in adoption procedures.

Physicians are *essential.* It would be *impossible* to carry on a good child placement program without them.

That is the view of Miss Mary Weaver, supervisor of adoptions for the State Department of Public Welfare's Division for Children and Youth.

To give you an example:

A few years ago the state had under its care an infant under one year whose birth record and subsequent history indicated it might have hydrocephalis (so-called waterhead) and/or slight spasticity. Through a series of medical tests and examinations, the hydrocephalis condition was ruled out, but the possibility of the spasticity remained.

A FORUM FEATURE

The development of the child as to physical growth and intelligence appeared normal or above. Applicants interested in taking the child into their home asked for the advice of a pediatrician they knew, and his understanding approach and assurance wiped away undue anxiety.

The story had a happy ending.

FEARS DISPELLED

The doctor told the future parents that a slight physical handicap might exist for some years, but that other capabilities of the infant would not be impaired.

Without this counsel, without this assurance, it is most likely the state would have experienced much difficulty in finding a home for the baby, Miss Weaver said.

Without exaggerating the point, it also is likely the child would have continued for many years as a ward of the state.

AID VARIES

Physicians give varied assistance in placement. Routine aid consists of procuring information relative to pre-natal care of the mother, the birth history, the existing conditions which might require special medical attention later and similar details. It is also routine to maintain case histories of the growing youngster, and recommendations to be followed in relation to observation and treatment can make continuous medical care a likelihood.

REPORTS ESSENTIAL

When good medical reports and social history are not available, early placement is not likely, and brings in numerous headaches.

Medical testings of the adoptive parents are required, too. Physicians were described as helpful in reporting these findings, in citing attitudes toward proper medical care, and in recommending follow-up treatment. It is helpful, too, when a doctor can help the case-worker understand what personality changes might be expected with certain medical conditions.

There are times, too, when adoptive parents are handicapped in some way. Assistance from the physician in understanding the extent of the handicap, the need for treatment, ability of the applicants to accept the handicap and to lead a fairly normal life is important for an agency's understanding of the suitability of the applicants.

IDEAS CHANGE

The idea that children must be perfect in order to be placed for adoption was tossed out the window a few years ago. Youngsters

(Continued next page)

(Children's Bureau Photograph by Esther Bubley)

IMPORTANT!

This article is the first in a two-part series dealing with the doctor's role in adoption matters. This initial article deals with what is legitimate, and proper. REMEMBER!—The Wisconsin Children's Code states a physician **cannot:**

1. Suggest to any unmarried mother, a natural parent or guardian any particular foster parents for an infant whom he deems available for adoption.

2. Offer to find foster parents for such a child.

3. Offer to find a child for adoption by prospective parents.

4. Place a child with foster parents on a trial or any basis.

5. Act in any other way as a negotiator or intermediary in such matters.

6. In any other way risk possible violation of the Code, under criminal penalties for violation.

These points cannot be stressed too much!

ADOPTIONS . . .

(Continued from page 308)

who have definite handicaps or who have conditions needing medical treatment are placed for adoption regularly. It is up to the agency to determine what couples among their applicants can accept such stiuations.

This, of course, is another aspect of the physician's role that has been of great value. His willingness and ability to explain conditions, and to assume responsibility for his findings are paramount.

CONSULTATIONS HELD

Several years ago a child came from a family with a hereditary ailment which disturbed caseworkers. Consultations were held with neurological specialists who believed that although no prediction could be made as to whether the child would ever develop the condition, they were sure any such development would not be extreme, or disabling. Careful screening followed, and an interested couple was found.

The prospective father and mother discussed the situation at length with the neurologists, and told of its meaning and implications. The physicians were most helpful in various ways. The adoptive parents were convinced and proudly claimed the newcomer for their own.

SPECIAL CARE NOTED

In a slightly different case, a little boy was under care for a severe condition threatening not only his development but his life. This required an unusual form of surgery. A pediatrician became interested, and performed the surgery without charge. The little fellow recovered fully, and eventually was placed in an adoptive home. The surgeon was interested in learning subsequent effects. Arrangements were made for him to see the child and speak with his new parents. Again, the doctor's thoughtful assistance proved to be of immeasurable value, and insured the well-being of the boy. Anxieties relative to future development were erased.

OCCASIONAL SLIP-UPS

There are instances in which more medical help could have been given. Because it was not, unfortunate circumstances developed. In one case, the adoptive couple was given a clean bill of health by a physician. However, there was a medical condition involving an unpleasant personality change which was not detected. Case records show the child was rejected by its new parents, abused and had to be removed from the home.

Another example: An applicant was reported in good health, but very soon after placement he was referred to a sanatorium because of tuberculosis. It was learned the physician was aware of the applicant's disease, but underestimated its potential.

MD'S CONSCIENTIOUS

"Such an appraisal," a State Department of Public Welfare spokesman said, "is very rare. Fortunately, we have found that physicians for the most part are very conscientious in assisting workers to understand just what medical problems might affect the children in an adoptive home.

"Appreciation should be given, too, to the pediatricians and other MD's who have been so patient and understanding in helping foster parents. These parents need assurance that immediate effects of treatment cannot always be expected, and that following directions closely will eventually effect improvement or cure."

Physicians can and do help in other phases of the adoption program. Unmarried mothers often are frightened and require sympathetic counsel. Young girls especially will look to the doctor for care and advice. He is urged to convince her that a *licensed* child placement agency is *the* resource through which her child can be placed, and that such an agency should be consulted as to the best way to do this.

LEGAL, ILLEGAL

Adoption is a social service, in which the MD plays a vital, generally unsung role. It has no magic formula.

State laws make it illegal for a doctor of medicine to participate in direct placement. A complete article on the factors relating to lawful and unlawful procedures in adoptions will be discussed in Part 2 of this series.

"To All My Patients" Still Available

Madison—Copies of "To All My Patients," a public relations pamphlet published by the AMA, are available without charge in the public information office of the State Medical Society.

Map Plans for Medical Assistants' Gathering

Milwaukee—The Wisconsin State Medical Assistants' Society, which held its organization meeting last spring, will meet here June 16–17.

Invited to speak at the annual gathering were Leo E. Brown, Chicago, Director of Public Relations for the AMA, and Mrs. Stewart Honeck, Madison, an authority on feminine poise and fashions.

The weekend program will begin with registration at 4 p.m. on Saturday, June 16. Mrs. Honeck will speak after 6 p.m. dinner. Registration will continue the next morning at 10:30 a.m. Then follows a business meeting, election of officers and dinner, at which time Mr. Brown will speak.

The Society has approximately 250 members.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE

policies are not terminated nor are benefits reduced because of age.

T.I.C.

TIME

INSURANCE COMPANY

MILWAUKEE WISCONSIN

URGE IMPROVED INTERPROFESSIONAL RELATIONS

Marquette Gathering Lays Stress on Better Cooperation

Milwaukee—*"What the United States needs today is not a legislated program of health care, but a program led by the health professions which will bring about a decrease in costs."*

That was the view expressed by Dr. Robert Moore, vice chancellor of the Pittsburgh Schools of the Health Professions. He spoke at Marquette University's 75th Anniversary Conference in late January on "Interprofessional Cooperation for the Improvement of Our Health and Welfare."

He said:

"The health professions have increasingly accepted the objective to minister to the physical ills of man but this curative medicine represents only a small part of our responsibility. Other major responsibilities are preventive and comprehensive medicine, teamwork and utilization of health care."

Prominent representatives of medical and para-medical professions participated in Marquette University's 75th anniversary conference on "Interprofessional Cooperation for the Improvement of Our Health and Welfare" in Milwaukee. Those taking pat included (seated, left to right) The Rt. Rev. Donald A. McGowan, director of the Bureau of Health and Hospitals of the National Catholic Welfare Conference, Washington, D. C.; Dr. John S. Hirschboeck, dean of Marquette's School of Medicine, and conference chairman; and standing (left to right), Dr. Thomas M. Rivers of the Rockefeller Institute for Medical Research, New York City; Dr. Stanley E. Dorst, dean of the College of Medicine, University of Cincinnati; Dr. Herman G. Weiskotten, dean emeritus of the University of Syracuse Medical School, and Dr. Robert Moore, vice chancellor of the Schools of the Health Professions of the University of Pittsburgh.

Dr. Robin C. Buerki, executive director of the Henry Ford Hospital in Detroit, said that without medical teamwork in the modern hospital "we will find ourselves in real trouble shortly."

He said:

"The problem is growing and we are not doing much about it."

Dr. Maynard K. Hine, dean of the Indiana University School of Dentistry, urged increased effort to draw the professions of dentistry and medicine together.

"Because of a lack of information," he said, **"the physician many times has no confidence in or understanding of the contributions a dentist can make in the treatment of oral disease, so proceeds with a treatment plan without consulting the dentist."**

Many patients, particularly older persons, have been allowed to become unnecessarily dependent, despite tremendous advances in rehabilitation medicine since 1940, **Dr. Howard A. Rusk** told the conference. He is chairman of the Department of Physical Medicine and Rehabilitation of the New York University Bellevue Medical Center, New York City.

"These patients are absorbing services of a vast corps of health personnel who could be freed for other essential services if some new approaches were made to patient care," he said.

Dean Stanley E. Dorst of the University of Cincinnati College of Medicine urged reorganization of the nation's medical specialty boards to provide an "integrated, intelligent authority."

"Excessive specialization will explode the profession into chaotic fragments," he said.

Another speaker, **Dr. Herman G. Weiskotten**, Skaneateles, N. Y., said the doctor must remain responsible for treatment and prevention of disease. He said:

"All groups involved in the health and medical care of the American people . . . must realize that pooled abilities cannot be a substitute for the physician's capacity and responsibility in the prevention, diagnosis and treatment of disease."

Urge Changes in Nursing Training and Education

Chicago—There would be no nursing shortage if certain changes were made in duties and in nursing education, two writers declared in a recent issue of *Hospitals*, Journal of the American Hospital Association.

Dr. A. W. Snoke and **Richard Ogrean**, New Haven, Conn., Community Hospital Director, said:

UNWISE PLANNING

"Responsibilities for clerical, housekeeping, dietary and administrative activities should be taken from the nurse and given to other personnel. We believe that uneconomical and inefficient use of graduate nurses in non-nursing activities can be demonstrated in every hospital in the country—including own own!

URGE EXPANSION

"There should be both diploma and collegiate nursing schools. Practical schools should be encouraged and expanded under auspices of state and voluntary agencies."

VIEWS ON ORGANIZED MEDICINE CHECKED BY AMA

ON THE AMA . . .

Chicago—How does the AMA rate with American physicians?

The survey showed only 7 per cent of AMA members are critical of the Association (while 10 per cent of non-members said they have negative impressions.

Half of the 500 physicians interviewed said they regarded their own county and state societies as a part of the AMA.

The physicians were generally agreed that:

People ascribe more laudable purposes to AMA than physicians expect them to.

GOALS OUTLINED

Public relations, legislative interest and improvement of medical care are the Association's major aims for the public. And that promoting professional standards, keeping them informed and public relations are the AMA's main objectives for doctors.

The AMA is not prejudiced against a particular group of people or doctors.

Present AMA standards for hospitals and medical schools are satisfactory.

TV POTENT

Television shows are more effective public relations media than radio programs or pamphlets.

They are more active in AMA than in other organizations.

Many doctors do not know the dues charged by AMA. (49 per cent offered an incorrect figure or said they did not know it was $25 annually). Sixty-eight per cent of them believe they get full value for their payments.

Other findings included:

About 75 per cent said the AMA either enters into politics about the right degree or not enough. Only one doctor in six said the AMA is too active politically.

PROPER CONTROL

Two of three doctors said the AMA has about the right amount of control over individual doctors. One in eight said it doesn't have enough.

Thirty per cent said articles published about the profession generally have a good effect; 25 per cent said the net effect has been bad.

Thirty-five per cent of the physicians said they joined AMA because of "custom, it's the doctors' organization."

JOHN Q. PUBLIC . . .

Chicago — Most people have a higher regard for their own family doctor than for doctors generally, a nationwide survey sponsored by the AMA disclosed in Feburary.

At least 82 per cent of the people interviewed had a family doctor.

The survey showed that the things disliked most about some physicians were:

1. Their charges, interest in money (18 per cent cited this). 2. Don't take time, hurry too much (nine per cent). 3. Impersonal, cold (nine per cent). 4. Not frank, speak half-truths (nine per cent).

SOME MD'S UNAVAILABLE

Of those questioned, 87 per cent said their doctors took sufficient personal interest, and 54 per cent thought it was true of most doctors; 19 per cent said their physicians were hard to reach for emergency calls, and 51 per cent thought it was true of most MD's; five per cent said their doctors were too quick in recommending operations, and 31 per cent thought that was true of most doctors.

As to whether doctors are highly intelligent, 98 per cent said it *"certainly was true"* of their physicians, while 93 believed it was true of most members of the profession.

The survey, made by Ben Gaffin and Associates, Chicago, drew this conclusion:

RE P/R

"It is not the public relations of the individual physician which require increased attention, but the public relations of the medical profession as a whole."

ON THE DOCTORS . . .

Chicago — Doctors of medicine, according to the AMA survey:

Expect more criticism of their fees than actually exists.

Are more critical of themselves than the public is on such matters as giving patients enough time, hiding other physicians' mistakes and thinking they are better than other people.

CRITICISMS OVER-STRESSED

Feel certain criticisms, such as those relating to haste in recommending operations, unavailability for emergencies, lack of personal interest, charging more to patients with insurance, are exaggerated.

Generally agree that the Salk polio vaccine program reflected credit on their profession.

Are divided on adequacy of insurance plans, with less than half of them satisfied at present. They suggest wider coverage as the best means of improvement of prepaid medical and hospital coverage.

Believe reports of fee splitting are exaggerated. (54 per cent of the general public told survey people they never heard about it.)

LIKE IKE'S

Agree with the general public that the best way to settle patients' complaints about doctors is by local grievance committees.

Said their own personal political philosophy is more like President Eisenhower's than like the late Robert Taft's or Franklin Roosevelt's.

Five hundred physicians were interviewed in the survey, undertaken to find out what complaints people have about doctors, and to learn M. D. reaction to current trends and practices.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

SHORT TAKES

REMEMBER!
Your Annual
Meeting in
Milwaukee
May 1, 2, 3

Donations to the SMS Scientific and Charitable Foundation now total $6,335.50, and have been received from 551 persons, some non-medical. **Six students have received loans from the Foundation; 23 others from the Student Loan Fund.** First meeting of the trustees will be held in May, perhaps during the Society's Annual Meeting . . . *Reserve May 1–2–3 for that all-important meeting in Milwaukee!* . . . **We wonder —Apparently some individuals are setting themselves up as free lance experts in medical public relations.** One county society in Wisconsin has been contacted. Others have in other states. If you become interested in some individual, you might write this office for further information. **And our staff is prepared to help county medical societies too!** . . .

Comment received on publication of Walter P. Reuther's letter in the January Blue Book issue of the Wisconsin Medical Journal (Forum section: ". . . *am proud to be a part of a medical society which has achieved social maturity so as to publish the letter of a labor leader. What was the point of it being published?*" . . . The letter, carrying Reuther's views on a proposed increase in prepaid hospital care cost in Michigan, was published to show a problem in a neighbor state and the increased interest and activities of an international union, in this instance UAW–CIO, which Reuther heads, in health care insurance.

The SMS office has a supply of pamphlets prepared by the *Wisconsin Bar Association* on the subject, **"Wisconsin Adoption Laws."** Members may secure copies by writing this office at Box 1109, Madison . . . Insurance as a mechanism of financing medical care for the indigent is receiving increased attention. **Private firms are discussing this presently, but recognize that such a program involves negotiating a schedule of benefits with the various professional groups concerned.** *Also under consideration:* Some form of interplan re-insurance on excess loss.

Chapter V of Welfare regulations recently sent county medical societies has produced diverse reactions. **One valuable side result is the study of fee arrangements now starting up all over the state.** *Reminder!*—Minnesota has a state schedule *below* which counties may operate . . . but not *above!* . . . Care at government expense for the dependents of men in service may ultimately be rendered under an arrangement similar to that which now exists for hometown care of veterans.

Outagamie county physicians and lawyers (left) met in Appleton in late January to discuss the Interprofessional Code, a set of objectives devised by members of both professions to improve understanding and procedures of operation. One of a number of joint sessions being held in Wisconsin, the meeting brought out a variety of problems, and a general discourse on what the guests don't and do like about the way members of the medical and law fields do business. An Appleton Post-Crescent photographer found the above group busy at work. Seated (left to right) are Dr. J. C. Griffith, Milwaukee, past-president of the State Medical Society of Wisconsin, and Atty. Samuel P. Myers, Racine, of the Wisconsin Bar Association. Standing are Drs. Victor F. Marshall and George T. Hegner, of Appleton, and Attys. George Hannagan and Patrick Couglin, Appleton. The Code was prepared jointly by the Grievance Committee of S.M.S. and the Committee on Interprofessional Relations of the W.B.A.

BLUE CROSS MEMBERSHIP NOW 50,179,264

Chicago—The fact is:

The 50 million members belonging to Blue Cross today represent the largest number of individuals ever banded together in North America for a single purpose.

Nearly one of every three persons in the U.S.A. is a Blue Cross member.

HUGE GROWTH

A depression project—Blue Cross started in 1929—the initial plan has mushroomed to 86 Approved programs, each one described as an independent, locally-governed, non-profit corporation.

In Wisconsin, Blue Cross listed 368,120 contracts, with 932,000 persons covered, as of Dec. 31, 1955.

Blue Cross Plans offer the only hospitalization program officially endorsed by the American Hospital Association. More than 6,000 hospitals participate in the program, receiving more than 885 million dollars in 1955 for caring for eight million persons.

FOLSOM COMMENTS

When the BC Commission reported in February it had attained a membership of 50 million members, Marion B. Folsom, Secretary of Health, Education and Welfare, commented:

"Voluntary health insurance is the best way for most people to protect themselves. . . . These are important milestones in advancement of health insurance. More and more Americans are now aware that the costs of unexpected illness should be a part of prudent planning for the future."

SOCIAL SECURITY . . .

(Continued from page 307)

dollars, a figure so vast that all it has for comparison is the national debt of approximately the same size.

"It is estimated that in 1975 total Social Security collections will approximate 20 billion dollars annually, an extremely conservative figure, under the amendments. This makes no allowance for changes in wage levels and would mean payments by many persons amount to *more* than they pay for federal income tax.

"You cannot expect double duty of the same tax dollar.

LIMIT TO TAXES

"I think it is a cruel joke on the part of the government to say, as if it were giving something with a lavish hand: '*After you are 72, doctor* (or lawyer, accountant or engineer), *you can earn all you wish to, and we will still pay back to you some of your contributions which began years ago!*

"We must remember there is a limit to the Social Security taxes the people may be willing to support the system in all the years ahead."

The resolution in full:

WHEREAS, H. R. 7225, which would amend the Social Security Act, was adopted by the House of Representatives in 1955, and is now before the United States Senate; and

MEDICINE EXCLUDED

WHEREAS, That bill includes provisions for disability insurance benefits beginning at age 50 in certain cases; for the continuation of insurance benefits to certain minors who were disabled before age 18; and extends coverage on a mandatory basis to all self-employed health professions, other than that of medicine, and to other professions as well; and

WHEREAS, Mrs. Oveta Culp Hobby, former Secretary of the Department of Health, Education and Welfare, in the course of a statement before the Senate Committee on Finance on July 26, 1955, warned against the adoption of H. R. 7225 in its present form because there had not been adequate opportunity to consider certain of its provisions; to correlate them with earlier adopted portions of the Social Security system; to evaluate amendments to the Social Security Act made in 1950 and in 1954 which involved parallel fields of health or benefits; and because the bill failed to take a realistic approach to the costs of the benefits provided by it.

Be It Therefore Resolved, That the State Medical Society of Wisconsin, comprised of more than 3200 practicing physicians, by its governing body, the Council, in meeting assembled at Madison, on February 25–26, 1956, after careful deliberations on H. R. 7225, with particular consideration of the implications of the bill for physicians, as practitioners of medicine and as citizens, urge the Senate of the United States to defeat that bill because it contains provisions to:

1. Establish a disability insurance system for certain persons 50 or over.
2. Continue insurance benefits for minors over 18 who are disabled before attaining age 18.
3. Force self-employed professional workers in health and other fields, exclusive of medicine, into the Social Security system.
4. Propose increases in Social Security tax rates.
5. Establish an Advisory Council on Social Security Financing.

LIST OBJECTIONS

Be It Further Resolved, That the basic reasons of the Council of this Society for urging the defeat of H. R. 7225 are as follows, with reference to the five provisions to which objection was made above:

1. The disability insurance system proposed for those 50 and over would be established by the bill without due consideration of the following factors, among others:

(a) the size and extent of the disability problem;

(b) the estimate of experts in rehabilitation and retraining that up to 97 per cent "of all handicapped persons can be rehabilitated to the extent of gainful employment";

(c) an apprehension, amply demonstrated in the veterans' program, and elsewhere in fields involving physical and psychic injury, that cash disability benefits often operate as a deterrent to rehabilitation and the return to gainful employment;

TIE-IN QUESTIONED

(d) the implications for the Social Security program of grafting a cash disability system of unknown, but unquestionably very substantial proportions, onto that system;

(e) the requirement that physicians certify disability under the unrealistic definition contained in Section 103 of the bill, which is totally deficient in the safeguards and reference points which reduce abuse in other fields of compensable injuries. We have particular reference to the relationship to employment which must be established as a condition of recovery in workmen's compensation cases; to service connection before there can be any determination of the right to disability benefits in the veterans' program; and to the factual background which in a large number of cases is established, in part, by third persons in negligence cases; and to specific phrasing in contracts of disability insurance issued by commercial companies. Objective standards to assist in determination of disability are neither provided for nor apparently anticipated by H. R. 7225;

DANGERS APPARENT

(f) the inevitable impairment and possible destruction of the personally significant and the economically and socially desirable programs established by the federal and state vocational rehabilitation statutes;

(g) the astronomical costs of the disability insurance and other provisions of the bill, which the chief actuary of the Social Security Administration estimates will add an average of not less than two bil-

(Continued on next page)

RENAMED COUNCIL CHAIRMAN

Dr. R. G. Arveson

SOCIAL SECURITY . . .

(Continued from page 313)

lion dollars per year to the costs of that system.

MISPLACED EMPHASIS?

2. A disability program for minors over 18, who were disabled prior to age 18, would be established without study of the problem, *without weighing* the federal and state machinery now available for its solution at state levels, and *without regard* for the other factors named in the objections offered above with reference to disability insurance for those over 50; except that this Council thinks that protest over the emphasis on cash benefits rather than training or rehabilitation programs for handicapped youth should be even more vigorous in the case of those who have not ordinarily begun their productive work than in the case of those who have spent much of their lives productively employed, as is undoubtedly true of the major portion of those disabled at or after age 50.

EXTENSION UNREALISTIC

3. **The mandatory extension of coverage to certain self-employed professional workers in 1954, and the attempted extension of coverage on a mandatory basis to all the remaining self-employed professional workers, with the exception of physicians, in H. R. 7225 is believed unrealistic in that it violates the actual pattern of productive activity of professional workers, and unjust because it is an ill-disguised method of tapping the incomes of such persons in full realization that the professional self-employed, as a group, will not derive benefits from the Social Security system proportionate to the taxes paid by them.** While the medical profession is fully cognizant that it is the sole professional group remaining exempt, should H. R. 7225 be enacted in its present form, this Council regards such an exemption as nothing more than a reprieve rather than as a continuing exemption from mandatory coverage. The Council expresses the further observation that the financing of the Social Security system has become in effect a gross income tax which will have no income ceiling if the benefits continue to rise as they did in 1950, 1952 and 1954.

COSTS, BENEFITS UNBALANCED

4. The objection to the rates proposed is that they are not increased sufficiently to equal the true cost of the benefits, and that they represent a continuation of the pattern which the Congress has followed consistently since 1939, of adding time after time to benefits without adding proportionately to the taxes assessed to pay for those benefits. In light of the evidence already placed before the Congress to the effect that the present Social Security Trust Fund is not adequate to pay benefits to present beneficiaries, much less to establish reserves for the time when present contributors, or their families, will themselves become the beneficiaries of the Act, it is believed essential to the very integrity of the basic Social Security program and to its direct and indirect influence on the country's economy, to make adequate changes in the tax rates *rather* than to continue temporizing with these vast obligations which will rapidly and inevitably fall due, and which are estimated at two hundred eighty billion dollars at this time.

NOT FAR ENOUGH

5. Although the establishment of the Advisory Council on Social Security Financing **"for the purpose of reviewing the status of the Federal Old-Age and Survivors' Insurance Trust Fund in relation to the long-term commitments of the old-age and survivors insurance program,"** as provided in Section 107 (a) is a step in the right direction, the Council objects to this provision on the basis that it does *not* go far enough. It is doubted whether such an advisory council would have jurisdiction over a number of the basic provisions of H. R. 7225 to which exception has been taken earlier in this Resolution.

STUDY URGED

It is believed much more relevant and fundamentally sound for the Congress to make no further changes whatever in Social Security legislation until it has first authorized and either conducted or arranged for an impartial study of the Social Security system as it now exists, the direction which it is taking, and the complete costs of the system, however it is to be continued.

EVALUATION ESSENTIAL

Be It Further Resolved, That the provisions in H. R. 7225 to which exception has earlier been taken in this Resolution, are believed to be of such a fundamental nature that they do not admit of compromise, and should in no event be enacted into law before a genuine and objective study has been completed by the Congress and the Department of Health, Education and Welfare, and the full findings of such study have been made public, *with adequate time for evaluation and reactions by the public.* It is believed that if the Social Security system is to continue on a sound basis, and is to **fulfill its two original purposes, namely, to provide a basic pension for workers who have been taxed by the program, and survivorship benefits to the families of such workers,** and if the substantial inflationary elements in the current administration of the Social Security program are to be kept under control, the time required for such a study must be taken without further delay, and the future of the program plotted in light of such findings.

STATE MEDICAL SOCIETY
OF WISCONSIN

ON THE S.M.S. CALENDAR . . .

April

3—9th District Meeting, Stevens Point.
3—Claims Committee, SMS.
8–12—Blue Shield Conference, Hollywood, Fla.
12—School Health Conference, Plateville.
12–3rd District Meeting, Madison.
19–6th District Meeting, Appleton.
30—*SMS Council*, Milwaukee.
30—SMS Golf Tournament, Milwaukee.

May 1–3—ANNUAL MEETING, MILWAUKEE!

AMEF Reports Contributions

Chiago—The American Medical Education Foundation reports the following Wisconsin physicians have sent contributions this year:

Drs. James E. Albrecht, Jackson; Paul M. Cunningham, Appleton; Donald L. Knutson, Milwaukee; Donald W. McCormick, Fond du Lac; Ovid O. Meyer, Madison; Wallace L. Nelson, Wisconsin Rapids and **Joseph B. Schrock,** Sharon.

Progress Report on the Wisconsin Maternal Mortality Survey

By the STUDY COMMITTEE

Division on Maternal and Child Welfare of the Commission on State Departments

Introduction

THE Study Committee has now completed a survey, study, and review of the maternal deaths which have occurred during a second 12-month period in the State of Wisconsin. In this report it is desired not only to give the statistical data concerning the deaths which have occurred during the time which this study covers, but in addition to make comparisons with the data included in the report of the first 12-month period of study. By doing this now and for the years to come, differences in causative factors of maternal demise and also the progress as the result of these studies can be noted.

During the past year, and as a result of our first 12-month study, the data obtained then were carefully reviewed and a series of slides made. This material was presented to about 60 different groups in the State of Wisconsin. In addition a summarized report was published in *The Wisconsin Medical Journal*. Following this, for several months, there appeared articles written by the various members of the Study Committee dealing with the major causes of death as found by the committee and outlining methods of prevention and treatment of these conditions. In certain instances where hospital facilities were thought somewhat insufficient to provide the very best of care, suggestions were given as to how improvement could be made. The newer methods for determination of blood clotting defects were thoroughly explained, and the use of fibrinogen advocated. There was a general appeal made for more extensive prenatal care, for the increased use of clinical and x-ray pelvimetry, for closer supervision during labor, for the anticipation and arrangements for blood to be available in all cases where bleeding, however minimal, was manifest. Since deaths from hemorrhage lead the list, it was emphasized that the physician in attendance should search for the cause of bleeding at the time it occurs postpartum; and then, in the event of a cervical or vaginal wall laceration, repairs should be made at the time. In the event of uterine rupture, laparotomy with repair or hysterectomy should be done rather than depending on oxytocics and packs with eventual surgery when the patient is moribund and almost certain of demise. Certain other factors such as manual dilatation of the cervix were pointed out as being hazardous and seldom, if ever, indicated. Version and extraction was advised only for the most certain indications, and only when the conditions for performing it were present; that is, complete dilatation, nonobstruction, and the patient under a completely relaxing type of anesthesia. Certain other dangers such as the injudicious use of oxytocics for the induction of labor, especially in the grand multipara, were stressed, as well as the better stabilization of the preeclamptic and eclamptic patients prior to termination of pregnancy. It has been the aim of the Study Committee to fulfill the purpose of the study by bringing such material as gained before as many of us who are caring for the expectant mothers as possible. Then by a full realization of where the margin of error lies, we can improve ourselves and provide better factors of safety for our patients.

Reduction in Maternal Mortality and Preventability Rates

The current study involves 91,570 live births during a 12-month period. There were 62 maternal deaths. Thirty-one of these were determined by the Study Committee to be deaths from pure obstetric causes, and thirty-one from associated causes of a nonobstetric character. The maternal mortality rate for this period of study, due to deaths from obstetric causes is 0.339 per 1,000 live births as compared to the rate for the previous period which was 0.43 per 1,000 live births as compared to the rate for the previveals a reduction of 0.091.

Of the 31 deaths due to purely obstetric causes, 15 were judged by the Study Committee to be possibly preventable. The com-

mittee has a full realization that at times the full circumstances are not available to it, and its members have attempted with a deep sense of responsibility to resolve these cases to the best of their collective and individual abilities. As compared to the current study there were 39 obstetric deaths in the previous study, and 26 of these were adjudged possibly preventable. We, therefore, have a marked reduction in the preventability rate in the second year of study.

Obstetric Deaths

Of the 31 deaths classified as obstetric deaths, 24 were associated with multiparity and 7 with primiparity. In the total live births of 91,570, twenty-five per cent of the mothers were primiparae and seventy-five per cent were multiparae. The death rate in these two groups is percentagewise equally divided. However, in the multiparous group the greatest death rate was present in those having had four or more pregnancies.

Autopsies were performed in 20 out of the 31 cases of obstetric deaths, and 21 consultations were requested and given in this group. In the previous study only 2 autopsies were obtained among 39 cases of obstetric deaths, and the number of consultations was considerably below the rate in the present series.

The causes of demise as reviewed by the Study Committee in these 31 cases are classified as follows:

Hemorrhage	16 cases
Preeclampsia and eclampsia	4 cases
Infection	2 cases
Embolic phenomena	9 cases

Hemorrhage

Since hemorrhage is the leading cause of death in this series it is well to look into the actual causes of hemorrhage.

Ruptured Uteri. There were 9 ruptured uteri in this series of hemorrhagic deaths.

There was one rupture of the scar of a previous classical section in late pregnancy and with no labor; demise occurred rapidly and before surgery could be done.

Two ruptures occurred in spontaneous labor and delivery. One of these resulted from the separation of an old deep cervical laceration and extended into the lateral lower segment of the uterus.

There were 2 ruptured uteri following manual dilatation of the cervix from statuses of 3 and 4 cm. respectively.

Two ruptures of the uterus followed version and extraction where nonrelaxing types of anesthesia were employed.

Two ruptures followed the use of intravenous Pitocin. In one case there was obstruction in the form of hydrocephalus, and in the other case induction was attempted pre-term on two occasions with an unripe cervix and because of a rising Rh antibody titer.

In the first 12-month study there were 15 ruptured uteri, and in this series there were 9. There were 2 ruptures following manual dilatation as compared to 6 in the previous series, and there were 2 version and extraction ruptures as compared to 4 in the first series. Two intravenous Pitocin ruptures—one in a case with an unripe cervix and one in a case of fetal-pelvic obstruction—had definite possibilities of danger.

The remaining hemorrhagic deaths were as follows:

Ectopic Pregnancies. There were 2 who died from intra-abdominal hemorrhage and shock before being operated. It is the unanimous opinion of the Study Committee that there is only one way in which to stop a bleeding ectopic pregnancy, and that is by surgery and the use of blood and more blood. Some of these cases may be saved even when profound shock has supervened.

Abruptio Placenta. Both of these cases had developed afibrinogenemia and were operated without determination of blood clotting defects and without the benefit of the administration of fibrinogen. The Study Committee feels that all of these cases should have the clotting mechanism restored before submission to surgery. Rapid methods of handling clotting defects and fibrinogen are available and should be employed.

Miscellaneous. Of the 3 remaining cases there was one intra-abdominal hemorrhage following the seventh cesarean section, one rapidly exsanguinating hemorrhage following delivery and an atonic uterus, and one acute inversion of the uterus with replacement and secondary reinversion.

Embolic Phenomena

There were 9 deaths due to emboli, and these were all proved by autopsy. They were as follows:

Pulmonary embolus, four hours postpartum.

Pulmonary embolus, six days postpartum arising from massive pelvic phlebothrombosis and following spontaneous delivery.

Air embolus at the beginning of the second stage and with abruption of the placenta at this point in labor.

Pulmonary embolus arising from pelvic phlebothrombosis; demise four days postpartum.

Pulmonary embolus arising from thrombosis in the vessels of a leiomyoma.

Amniotic fluid embolism with anaphylactic shock 10 minutes following the administration of 2 minims of pituitrin intramuscularly.

Pulmonary embolus four hours following spontaneous delivery.

Pulmonary embolus 10 weeks postpartum. Massive pelvic phlebothrombosis.

Air embolism following self-induced abortion. Air was injected into the uterus by means of a catheter and infant syringe.

Infection

There were only two deaths due to infection. One followed a cesarean section which was done after a long labor with ruptured membranes and no antibiotic or chemotherapeutic prophylaxis. The other death was due to septicemia following an attempted self-induced abortion by means of stuffing chicken feathers into the cervix.

Eclampsia

There were 4 eclamptic deaths: one patient died of a cerebral hemorrhage at the time of delivery; one died of a cerebral hemorrhage nine days postpartum; one died of pulmonary edema shortly following delivery by cesarean section; and one died with uncontrollable convulsive seizures following cesarean section.

Miscellaneous Nonobstetric Deaths

Miscellaneous causes of death not related to obstetric causes can be enumerated as follows:

There were 7 deaths due to severe cardiopathy.

There was one severe diabetic case which, under excellent management, could not be stabilized.

Three deaths were due to bulbar type poliomyelitis.

There was one case of chronic myelogenous leukemia.

Three deaths were due to chronic glomerular nephritis.

One death was due to a ruptured appendix with peritonitis.

One death was due to fatal gastric hemorrhage.

There were several other deaths due to severe respiratory diseases such as pneumonia, emphysema, and pulmonary tuberculosis.

There was one suicide with carbon monoxide poisoning.

Two patients were killed because of automobile accidents.

There were two anesthetic deaths—one caudal which became total, and the other following anesthesia, because of an obstructed airway.

Summary

This material presents the major and individual causes of maternal demise during the last 12-month period of study. Certainly one cannot deny but that there is marked improvement over the first period. Our maternal mortality rate has now reached a point where it is one of the lowest in the nation, but we should not be triumphant until the last obstacle to preventability is conquered. Perhaps that cannot ever be accomplished, but it should stand as a goal, the realization of which we can aim and hope for. For example, in this and the previous reports, hemorrhage is categoried as the outstanding major cause of maternal demise. This should not be, for many of the deaths due to hemorrhage are probably avoidable, first, by the avoidance of certain manipulative procedures such as manual dilatation of the cervix, and version and extraction except when properly indicated and then only when conditions are present for this performance and with deep relaxing types of anesthesia, and second, by the immediate search for the source of bleeding postpartum and for the prompt and proper attention to the control of such bleeding by immediate repair of lacerations or, if need be, the removal of a ruptured uterus. Blood clotting defects should always be anticipated in all cases of abruptio placenta, and these clotting defects should be remedied after diagnosed and before proceeding with termination of the pregnancy. Ectopic pregnancies should be operated when diagnosed. Of course, blood should be planned for and utilized to the fullest in all cases of obstetric bleeding. If the performance of manual dila-

tation, the improper performance of version and extraction, and the injudicious use of oxytocics for induction or stimulation of labor could be eliminated from our category of procedures, some of our hemorrhagic deaths could be prevented.

The Study Committee also makes a plea for the better control of the eclamptic patient prior to termination of the pregnancy, for the earlier hospitalization of those developing signs of preeclampsia, and for longer periods of hospitalization following delivery for the eclamptic with residual findings.

The medical complications of pregnancy assume quite a role in the causes of maternal demise. These should be diagnosed early by means of a complete physical examination at the first prenatal visit, and such complications should be carefully evaluated and carefully treated during the course of pregnancy. Adequate consultation not only can help the patient but also can assure her and her immediate relatives that whatever can be done is being done to enhance her safety. Much of the art of obstetrics depends on judgment, and we should be willing to complement that judgment by that of our associates. We are in this business together and should be helpful to each other.

The Study Committee extends its most sincere thanks to all those who have so willingly helped in conducting these studies.

MIDWEST REGIONAL MEETING, INTERNATIONAL COLLEGE OF SURGEONS, MADISON, WISCONSIN, APRIL 26–28, 1956

Thursday, April 26

4:00 p.m.—Annual chapter meeting to discuss past and present business and elect officers for 1956–57—Staff room, Jackson Clinic

5:00–7:00 p.m.—Registration—Loraine Hotel lobby

7:00 p.m.—Cocktails and dinner—Crystal Ballroom, Loraine Hotel (informal). For officers, regents, members and their wives

8:30 p.m.—Program

Dr. Ross T. McIntyre, Executive Director, International College of Surgeons
Dr. Geo. Callahan, Waukegan, Illinois—Illustrated talk on Far East

Friday, April 27

A. M.—Panel discussions on:

The Acute Surgical Abdomen
Gastrointestinal Hemorrhage
Biliary Surgery
Problems of Thyroid Surgery

P. M.—Panel discussions on problems in herniorrhaphy and colon surgery
Tour of Jackson Clinic, followed by cocktails and dinner and nonscientific entertainment, consisting of Mozart Glee Club and an illustrated talk on past European trips by Dr. Arnold S. Jackson

Saturday, April 28

A. M.—Panel discussions on renal lithiasis, ulcer surgical problem, management of hip fractures, and special surgical topics

Participants:

Out-of-state—Drs. H. E. Bacon, Curtice Rosser, Peter Rosi, Neal Owens, Ralph Coffey, Max Thorek, Manuel Lichtenstein, Chester Guy, Karl Mayer

Wisconsin—Drs. Arnold Jackson, Madison; Russell Kurten, Racine; George Ewell, Madison; H. Lewis Greene, Madison; Victor Marshall, Appleton; D. W. Witte, Milwaukee; Harry Kasten, Beloit; Luther Holmgren, Madison; Eugene Eckstam, Monroe; F. J. Krueger, Milwaukee; James Hoon, Sheboygan; Paul Doege, Marshfield; H. W. Mahaffey, Madison; Oscar Foseid, Madison; W. B. Hobbins, Madison; J. J. Mueller, Madison; H. R. Fehland, Wausau; John Steeper, Madison; J. W. McRoberts, Sheboygan

Registration Fee: $5.00

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: J. W. Erchul, M. D.

REPORT OF A CASE*

This 14-year-old white male first became ill in April, 1953, with the gradual onset of fatigue, pallor, lack of energy, and dyspnea on climbing stairs. He weighed 86 pounds and appeared pale, thin, and chronically ill. The oral temperature was 100.6 F., and the pulse 88 per minute and regular. A few crepitant rales were heard at each lung base, and there was a soft apical systolic murmur. Laboratory work at that time yielded a hemoglobin of 5.9 gm. per 100 ml., an erythrocyte count of 3.2 million per cu. mm., a leukocyte count of 8,750 per cu. mm., and a Westergren sedimentation rate of 25 mm.

After treatment consisting of rest and oral ferrous sulfate, he gradually gained weight and was able to attend school. In July, 1954, the weight was 111 pounds and the hemoglobin was 11.4 gm. per 100 ml. with 4.7 million erythrocytes per cu. mm.

First Hospital Admission: On October 25, 1954, he was hospitalized for a period of 16 days because of fatigue, pallor, and lack of energy. He had fainted twice in the previous 12 hours, and it was discovered that no iron had been taken for the past two months. The oral temperature was 102 F. The lungs were clear, and a soft grade II apical systolic murmur was heard. The spleen was enlarged 3 cm. below the left costal margin, and the liver was palpable at the right costal border.

Laboratory results were as follows: hemoglobin 4.7 gm. per 100 ml.; erythrocytes 3.2 million per cu. mm.; leukocytes 11,250 per cu. mm. with 62% segmented neutrophils, 11% band forms, 24% lymphocytes, 2% monocytes, 1% eosinophils, and occasional nucleated red cells; sternal marrow examination revealed erythroid hyperplasia; the blood was Group O Rh negative; bleeding, coagulation, and prothrombin times were within normal limits; total serum bilirubin was 1.4 mg. with a direct reaction of 0.95 mg. per 100 ml.; spinal fluid analysis and repeated urinalyses were within normal limits; cephalin flocculation was negative at 24 hours and 2+ at 48 hours. The following additional tests were performed and found to be normal or negative: first and second strength Mantoux tests; cultures of sternal marrow and blood for fungi and predominating organisms; cultures of gastric washings for tubercle bacilli and fungi; stool examinations for occult blood and ova; febrile agglutinins; heterophile antibody; cold agglutinins; urine examination for porphyrins; an electrocardiogram; x-ray of hands and wrists.

A chest x-ray revealed a diffuse, finely mottled density throughout both lung fields; this was more prominent centrally with focal calcification in the right hilum. The hilar nodes were moderately enlarged. Virtually complete clearing had occurred at the time of discharge.

The admission temperature of 102 F. returned to normal after two days. Treatment consisted of two transfusions and oral ferrous sulfate, and the patient was discharged on November 9, 1954, in a greatly improved state.

Second Hospital Admission. The patient had remained well at home for two weeks, when he experienced tightness in the chest with dyspnea and expectoration of small amounts of bright red blood. The temperature had varied between 100 F. and 101 F. Accordingly, the patient was again hospitalized on December 4, 1954.

The physical findings were not significantly changed from those in the previous examination.

Laboratory results were as follows: hemoglobin 11.7 gm. per 100 ml. with 3.85 million erythrocytes per cu. mm.; platelets 280,000 per cu. mm.; a stool positive for occult blood; serum iron 161 micrograms per 100 ml.; nonprotein nitrogen 41 mg. per 100 ml. Tests within normal limits or negative were as follows: histoplasmin skin test; thymol turbidity; cephalin flocculation; osmotic fragility of erythrocytes; direct Coombs' test.

* From St. Clare Hospital, Monroe, Wisconsin.

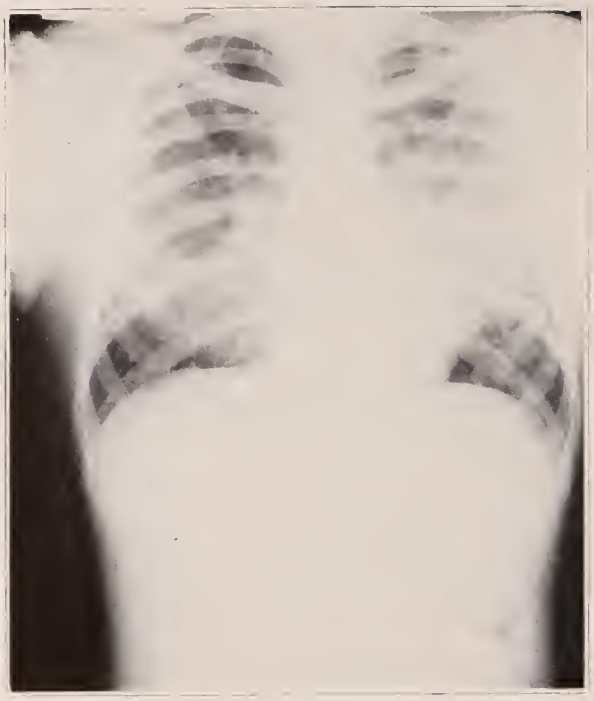

Fig. 1—Chest x-ray with bilateral granular densities, taken December 6, 1954.

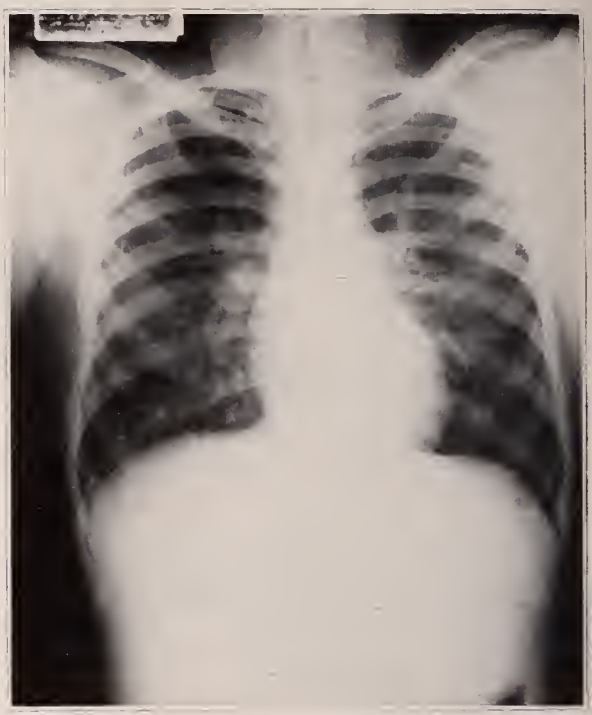

Fig. 2—Chest x-ray taken December 10, 1954, showing marked clearing of the previous densities.

A chest x-ray (fig. 1) revealed a diffuse clouding of the right lung field with a granular mottling in the left lung field. Foci of calcification were again seen in the right hilum. Four days later another chest x-ray (fig. 2) showed marked clearing on the left and regression of the changes in the right lung.

Treatment consisted of bed rest and oral ferrous sulfate. The patient was discharged asymptomatic on December 13, 1954.

Clinical Discussion

Dr. F. C. Stiles: Before trying to make a diagnosis on this interesting case, I would like to consider briefly the protocol as presented. This seems to be a chronic or recurrent infection in a 14-year-old male. Some pulmonary pathology seems to be a definite feature of this disease. The cough, dyspnea, hemoptysis, calcified nodule in the right lung, and increased densities in the chest x-rays point toward this. In addition, there is fever, severe anemia, hepatomegaly, and splenomegaly. The murmur is not clearly described. In the presence of severe anemia it would be difficult to ascribe great significance to this murmur. The anemia is certainly severe and probably results from infection, although nutritional anemia or a hemolytic process cannot be definitely excluded. It is noted that the total and direct bilirubin and nonprotein nitrogen are elevated and that the cephalin flocculation test is slightly positive.

Before going any further I would like to know if bacteriologic studies were done on throat cultures, from sputum, or after bronchoscopic examination?

Dr. J. W. Erchul: None are recorded.

Doctor Stiles: Tuberculosis definitely has to be considered in this case despite the negative skin tests. It is not stated if this child had night sweats or sputum; but cough, fever, hemoptysis, malaise, and weight loss all seem to have been present. The calcified nodule in the right lung lends support to this diagnosis. The appearance and the disappearance of the diffuse densities in the lung does not seem very typical to me, however. The rapidity of improvement seems odd, too, for an extensive tubercular infection.

The next possibility I would like to consider would be histoplasmosis. The fever, malaise, respiratory symptoms, weight loss, anemia, and enlargement of the spleen and liver all fit very nicely; and the one negative histoplasmin skin test in the patient doesn't

rule out this condition. Diffuse densities in lung x-rays and the calcified nodule are certainly suggestive of histoplasmosis. To establish this diagnosis, the skin tests should be repeated, and additional attempts should be made to demonstrate the organism, possibly from sputum as well as bone marrow.

A diagnosis of coccidioidomycosis must be excluded. A history of habitation in an endemic area is missing. To diagnose this, complement fixation tests and cultures from sputum or secretions would be desirable. The enlarged liver and spleen are not to my knowledge common in coccidioidomycosis.

Another possibility is a recurrent bacterial or viral pneumonia. Unless there was an accompanying septicemia, hepatosplenomegaly would be unlikely. The negative cold agglutinin test pretty well rules out any atypical virus pneumonia, and a higher leukocyte count would be expected with a bacterial pneumonia. Giant cell pneumonia of Hecht should be mentioned as a remote possibility.

Löffler's syndrome is a doubtful diagnosis but should be considered. Hepatomegaly can occur in this condition, which is usually characterized by an eosinophilia, however.

A very rare condition that could cause the pulmonary symptoms is idiopathic pulmonary hemosiderosis. During an acute attack there might be enlargement of the liver and spleen, probably due to congestion. Slight temperature is often found. Hemosiderin-laden macrophages should be found in pulmonary secretions.

Several other conditions must be considered. Brucellosis, which could cause low-grade fever, weakness, chest pain, cough, and even hepatosplenomegaly, is possible. Pneumonia due to *Brucella abortus* has been described. Porphyria is occasionally accompanied by splenomegaly, hemolytic anemia, and porphyrinuria. One of the reticuloendothelioses would be a remote possibility.

Finally, it is possible that this patient had more than one clinical entity, such as a primary generalized or pulmonary infection with a secondary hemolytic process.

In summary, my first choice as a clinical impression would be histoplasmosis, with the other conditions mentioned to be ruled out.

Doctor Erchul: We will now call upon Dr. J. M. Irvin, who was the attending physician in this case, to give his clinical impression and a brief discussion of this interesting condition.

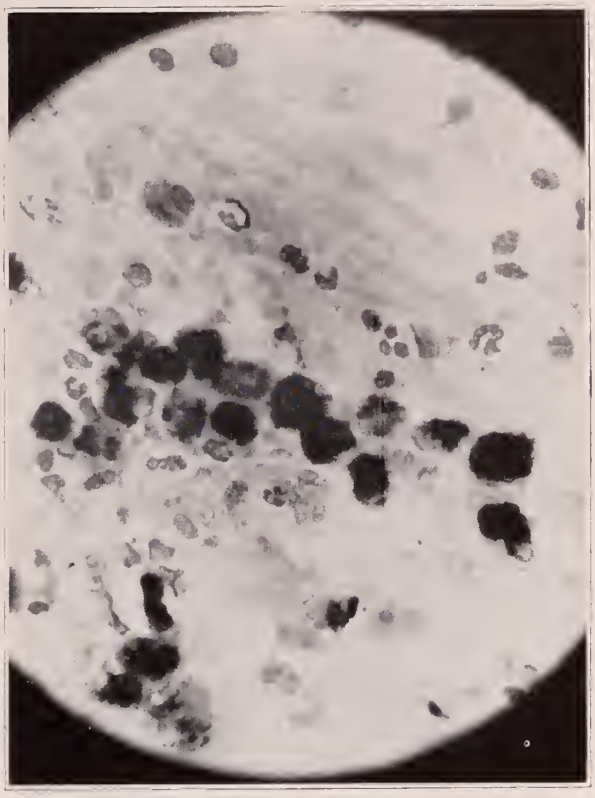

Fig. 3—Sputum stained with Perls' iron stain, showing numerous hemosiderin-bearing macrophages (X 600).

Dr. J. M. Irvin: We believe this patient represents a case of idiopathic pulmonary hemosiderosis. This is a rare disease of children characterized by intermittent pulmonary bleeding, progressive pulmonary fibrosis, hypochromic anemia, and eventual cardiorespiratory failure. About 34 cases have been described in the literature. Ceelen[1] first recognized the disease in 1931, and Wyllie[2] has presented the most comprehensive description.

The clinical course is marked by the insidious onset of fatigability, pallor, intermittent fever, and dyspnea. These symptoms plus the presence of a soft precordial systolic murmur of anemia may lead the clinician to suspect rheumatic fever. Acute episodes of dyspnea, tightness in the chest, tachycardia, hemoptysis, and fleeting cyanosis occur for periods up to several days and are related to intrapulmonary bleeding. These may be interspersed by longer periods in which the effects of anemia may be the only symptom. Transient icterus may follow an acute epi-

sode. As progression of the disease occurs, the symptoms increase in severity, and evidence of pulmonary fibrosis and cor pulmonale appears. Children may die early in the course of the disease with massive pulmonary hemorrhage or later with cardiac failure and pneumonia. Although generally considered a fatal malady, some spontaneous remissions have occurred; and it is thought that nonfatal cases exist and have gone unrecognized.

The x-ray findings in the chest coincide in appearance with the onset of the pulmonary symptoms. They are characterized by a usually centrally located granular mottling, which may migrate and change in character from day to day. Later, evidence of pulmonary fibrosis appears.

Significant laboratory findings included a peripheral blood picture of hypochromic anemia. The serum bilirubin may show a transient elevation, and occult blood may appear in the stool. The most significant laboratory finding is the presence of hemosiderin-laden macrophages in the sputum or in gastric washings.

Various explanations concerning etiology of this disease have been proposed. These include defective vasomotor control of pulmonary vessels with diapedesis of erythrocytes into the lung tissues, congenital deficiency of pulmonary elastic tissue, and alteration of the permeability of the lung capillaries by an antigen-antibody reaction in an autosensitized individual.

Addendum

Following the second period of hospitalization, numerous macrophages bearing hemosiderin were demonstrated on several occasions in both sputum and gastric washings from this patient (fig. 3).

A little more than a year has elapsed since the last hospitalization, during most of which time the boy has experienced mild transitory episodes of pulmonary bleeding every two to three weeks. The last attack occurred in August, 1955; and at present he has returned to school and is not anemic. Treatment until September, 1955, consisted of oral iron and cortisone. Since then the latter has been discontinued.

REFERENCES

1. Ceelen, W.: Die kreislaufstörungen der lunge, in Henke-Lubarsch: Handbuch der Speziellen Pathologischen Anatomie und Histologie, Berlin, Julius Springer, 1931, vol. III/3, pp. 1–163.
2. Wyllie, W. G., Sheldon, W., Bodian, M., and Barlow, A.: Idiopathic pulmonary haemosiderosis (essential brown induration of lungs), Quart. J. Med. 17:25–48 (Jan.) 1948.

POSTGRADUATE COURSE IN COMMON DIGESTIVE DISEASES OFFERED BY MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

A postgraduate course in common digestive diseases will be offered through the Marquette University School of Medicine, Milwaukee, on four consecutive Thursdays from 10:00 a.m. to 12 noon, starting April 5. The first three sessions will be presented in Room 109 of the medical school, the final session in the assembly hall of Milwaukee County General Hospital.

Joseph Shaiken, M. D., associate clinical professor of medicine at Marquette, will direct the course. M. C. F. Lindert, M. D., assistant clinical professor of medicine, will be co-chairman and a member of the faculty. Other faculty members for the course include Michael W. Shutkin, M. D., Robert E. Yunck, M. D., and Jack J. Levin, M. D., all assistant clinical professors of medicine at Marquette.

JOHN HARRIS MEMORIAL LECTURE FUND

A memorial fund has been established in memory of John Harris, M. D., late professor and head of the department of obstetrics and gynecology at the University of Wisconsin. The fund will be used to provide for an annual lecture at the University in the field of obstetrics and gynecology by some nationally known specialist in the field.

Contributions to the fund should be directed to John Z. Bowers, M. D., Dean, University of Wisconsin Medical School.

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Polls and Public Opinion

"Schrubbe charged that the American Medical Association had a 'strangle hold' on the practice of medicine, including hospitals, medical schools and even private community agencies. He said that, although the plans of the medical profession, Blue Cross and Blue Shield, had helped bring care to some extent to low income groups, they did not provide adequate coverage."

This quotation from *The Milwaukee Journal* of February 22 is attributed to the director of the Milwaukee County CIO Council's Community Service Committee. It is not a new charge. It has come from many sources — labor, farm, or otherwise. The tragedy of such statements is not alone in their basic falsehood—for anyone might not know the facts—but in their repetition to the point that one can conclude only that there is no attempt to learn the facts or, if they are learned, no effort to report them.

Some groups and individuals are obviously possessed by the strange philosophy that only the "blue collar" class is interested in the common welfare, that humanitarianism is a quality reserved to certain political parties, and that public service is a personal thing incapable of accomplishment by the group, particularly a medical group. It is as if the physician is a Doctor Jekyll–Mr. Hyde, kind and gentle to his patients but conniving and treacherous when conferring with his colleagues.

It is of little avail to refute the remarks quoted in *The Milwaukee Journal*, though it can be done easily and effectively. The speaker would only repeat it tomorrow in a letter, the day after in a bulletin, and the next on TV. Even a well-organized "truth brigade" would be worn out chasing these calculated comments.

One is forced to rely on the public's good common sense and its growing awareness that it cannot believe all that it hears and sees. This approach might be supported by the results of two recent public opinion polls.

The A.M.A.-sponsored poll concluded that most Americans like their own family doctor and like doctors as a group. It also seemed to show that people's opinions gained from their own experiences differ from those based on hearsay or other sources; that doctors are more critical of themselves than are other people; and that when people criticize physicians, it is largely for the cost of care. They do not, however, think doctors are trying to "get rich quick." Only half of the people surveyed said they had any knowledge of the A.M.A.; and of those who did, 43 per cent said their opinion of the A.M.A. was "all good," 26 per cent said it was "more good than bad," 13 per cent "about equal," 4 per cent "more bad than good," and 1 per cent "all bad."

Most of these people approved of the strictness of A.M.A. standards for medical schools and hospitals, and neither the public nor doctors surveyed were very critical of the A.M.A.'s political activities.

Closer to home, the *Wisconsin Agriculturist and Farmer* reported in a recent poll that most farmers don't complain too much about doctor fees and seem to feel that the service is generally good. The Wisconsin Agriculturist poll summed up the opinions of rural people on doctors:

> "They love and respect and trust their family doctor. Most people feel that fees are not out of line. They would like better service, although they are appreciative of the tremendous job which doctors are doing for them. They would like to train more doctors."

It is probably true that one can lie with polls as well as with statistics. Nevertheless, these two opinion surveys give heart to honest men who, knowing that neither they nor all their works are yet perfect, can be given the opportunity to do their best for public health.

Interprofessional Cooperation

Marquette University is to be commended for so wisely planning the observance of its 75th anniversary. Its series of academic conferences is a highly appropriate means of demonstrating Marquette's maturity as an educational institution.

Recently, the third of these conferences was devoted to "Interprofessional Cooperation for the Improvement of Our Health and Public Welfare." Major papers were presented to public audiences, but the panelists' views were thoroughly examined in closed seminars by persons from the medical and related fields involved.

Dr. John S. Hirschboeck, dean of Marquette University School of Medicine and chairman of the conference, summarized the meeting:

"The development of a spirit of cooperation is one of the most pressing needs in the health and welfare field.

"The need was created by the recent trend towards a high degree of specialization within the medical and para-medical professions and an increase in the number of nonmedical specialists who serve this area. The situation has been further complicated by the rapid growth of the many special disease interest groups.

"The increase in specialists and agencies working in this area has given rise to such important questions as: How should the boundaries between specialists be established? Who should be responsible for hospital operation, medical education, and the dispensing of drugs? Is the importance of some diseases being overemphasized? Who should raise and control funds for medical research?

"The Marquette conference was called in the hope of identifying and exploring the full complexity of these problems, determining more fully their relationship to one another, and stimulating suggestions for a program to establish the cooperation so necessary between the many medical specialists and agencies to improve our health and welfare."

The conference was particularly timely and turned out to be equally successful. The only sad part of the conference was the slanted coverage given by the press. They pointed up the criticisms made by the interallied professions of each other, yet failed to report the many areas of mutual respect and cooperation. Admittedly, newspapers thrive on controversy but they could do with more civic responsibility.

CONTINUATION COURSES AT UNIVERSITY OF MINNESOTA CENTER FOR CONTINUATION STUDY

Dates	*Name of Course*	*Guest Speaker*
April 7	Trauma for General Physicians	
April 9–11	Endocrinology for General Physicians	Dr. Peter H. Forsham, University of California Medical School
April 16–18	Radiology for General Physicians	
May 7–12	Electrocardiography for General Physicians	Dr. Harold Levine, Harvard University Medical School
May 14–19	Proctology for General Physicians	
May 24–26	Surgery for Surgeons	Dr. Robert M. Zollinger, Ohio State University College of Medicine
June 4–6	Dermatology for General Physicians	

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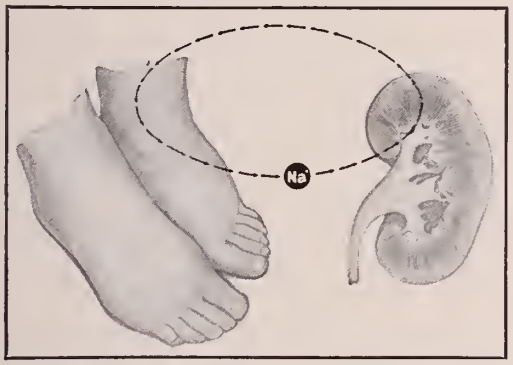
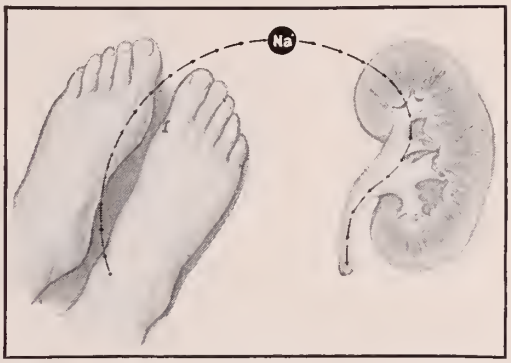


WITHOUT MICTINE — *Prior to diuretic therapy excessive sodium and water are characteristically retained in the edematous patient.*



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Mictine is orally effective; it is not a mercurial; it has no known contraindications; it does not upset the acid-base balance; it exerts no significant influence on electrolyte balance; it may be given in the presence of renal or hepatic diseases; it is well tolerated.

As with most effective therapeutic agents, in high dosage Mictine may cause some side effects in some patients; however, on three tablets daily side effects (anorexia and nausea, rarely vomiting, diarrhea or headache) are minimal or absent.

Clinically, Mictine is useful in the maintenance of an edema-free state in all patients and for initial and continuing diuresis in mild or moderate congestive failure. It is not intended for initial diuresis in severe congestive failure unless either sensitivity or tolerance to other diuretics has developed in the patient.

The maintenance dosage of Mictine, as well as for initial diuresis in mild or moderate congestive heart failure, is one to four 200-mg. tablets daily in divided doses; the dosage for initial diuresis in severe congestive failure, under the conditions already described, is four to six tablets daily. For either use, it is recommended that Mictine be prescribed with meals on interrupted dosage schedules; that is, prescribing Mictine on alternate days or for three consecutive days and omitting it the next four days.

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. . . . THE PRESIDENT'S PAGE . . . .

A STATE-WIDE campaign to secure the names and addresses of all Wisconsin residents suffering from arthritis and rheumatism will be conducted during April by the Wisconsin Pharmaceutical Association and the Wisconsin Chapter of the Arthritis and Rheumatism Foundation. Purposes of this mass registration are to provide arthritic patients with free authentic literature on the arthritis problem and to encourage them to see their family physicians if they are not receiving medical attention.

The State Medical Society has approved this campaign and urges all physicians to inform their arthritic and rheumatic patients to register at their local drug stores. An increasing number of arthritis patients are being restored to active normal lives through adequate medical attention, new drugs, and physical therapy. It is important, also, to extend a note of encouragement to these individuals, stressing that their cases are not hopeless. This registration will help provide this encouraging message.

Statistics, heretofore unavailable, on the incidence of rheumatic diseases in the State of Wisconsin will also result from this registration. It is indeed essential to know the magnitude of the problem of arthritis and rheumatism in order to properly plan anticipated treatment facilities.

This survey will contribute to efficient public health planning in this field, there is no question about it. It is heartening to see a task of this caliber being undertaken by a voluntary health organization and a professional association, cooperating to accomplish an important public service.

Congratulations to both groups for their progressive thinking and careful planning!

Irvin L. Bernhart M. D.

Society Proceedings

Ashland–Bayfield–Iron

Dr. Charles Ihle, Eau Claire, was the guest speaker at the February 15 meeting of the Ashland–Bayfield-Iron County Medical Society. He discussed "Fractures of the Spine." Thirteen members of the society were present at the meeting.

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met January 12 at the Elks Club in Green Bay and heard talks given by *Drs. John Huston, Robert W. Boyle,* and *E. G. Olmstead.*

Doctor Huston, who is physician in charge of the Cardio–Pulmonary Diseases Laboratory at the Marquette University School of Medicine and Milwaukee County General Hospital, and an instructor in internal medicine at Marquette, spoke on "Physiology of Cardiac Rehabilitation in Coronary Disease."

"Facilities and Methods of Rehabilitation in Coronary Diseases" was the topic chosen by Doctor Boyle, Assistant Professor of Physical Medicine at Marquette and Director of the Department of Physical Medicine, Milwaukee County General Hospital.

Assistant Clinical Professor of Medicine at Marquette, Doctor Olmstead, spoke on "Long-Term Medical Management of Coronary Diseases." Doctor Olmstead is also Assistant Director of Medicine at Milwaukee County General Hospital.

A short business meeting followed the addresses.

Fond du Lac

The February meeting of the Fond du Lac County Medical Society was held at the Elks Club in Fond du Lac, February 23.

Guest speaker for the group was *Dr. H. P. Maxwell,* Milwaukee, who spoke on "The Practical Neurological Examination."

Jefferson

Thirty-three members were present at the January 19 meeting of the Jefferson County Medical Society which was held at Roehl's Tea Room in Lake Mills.

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Dr. W. V. Luetke, Madison, spoke on the complications of obstetrics. Several announcements were made by the first district councilor, *Dr. W. D. James*. During the business session a discussion was held regarding the distribution of available polio vaccine.

Juneau

The regular monthly meeting of the Juneau County Medical Society was held January 26, and election of officers took place. The following doctors now preside: President, *Dr. J. H. Vedner;* Vice-President, *Dr. M. S. Tverberg;* Secretary, *Dr. J. S. Hess;* Delegate, *Dr. J. E. Thompson;* and Alternate Delegate, *Dr. V. M. Griffin*. All of the new officers are Mauston physicians.

Kenosha

On January 5, 40 members of the Kenosha County Medical Society met at the Elks Club in Kenosha. A movie was presented on cancer of the rectum, after which a business session was held. Preliminary reports by various committee chairmen were given, and it was decided that final reports would be presented at the February meeting.

A report of the December meeting which named the new officers for 1956 was read. Kenosha physicians elected include *Dr. J. T. Garren*, President; *Dr. L. M. Rauen*, Vice-President and President-Elect; *Dr. Helen A. Binnie*, Secretary; *Dr. D. N. Goldstein*, Delegate; and *Dr. H. L. Schwartz*, Alternate Delegate.

Forty-five members attended the meeting of the society held on February 2 at the Kenosha Elks Club.

"Diagnosis and Treatment of Peripheral Vascular Diseases" was the subject of the address by Dr. John Olwin, Department of Surgery, University of Illinois Medical School. The use of various types of artery grafts for lower extremities was shown.

During the business meeting, the Society members gave their unanimous approval to the establishment of public polio clinics.

Manitowoc

Harold Kugler, C. P. A., discussed the topic, "The Doctor's Tax Problem," at the meeting of the Manitowoc County Medical Society held on February 23. Twenty members attended the meeting, which was held at Wellhoefer's Sea Grill, Manitowoc.

Milwaukee

The Medical Society of Milwaukee County met February 9 at the Athletic Club in Milwaukee, and heard a discussion regarding heart ailments.

Guest speakers at the meeting were Dr. Richard J. Clark, Boston, Massachusetts, and Dr. E. A. Irvin, medical director of the Ford Motor Company. They discussed the problem of employment for persons suffering from heart ailments.

Doctor Clark cited heart cases where employment had actually helped considerably in improving the heart condition. Doctor Irvin, who is president-elect of the Michigan Heart Association, pointed

out that there was a great need for communication between private physicians and those in industry to solve problems of employing the cardiac patient.

Oconto

A movie, "Management of Streptococcal Infection and Its Complications," was shown at the February 21 meeting of the Oconto County Medical Society, held at the Lilac Club, Gillett.

Drs. F. E. Zantow, G. T. Mohler, and *L. E. Rauchschwalbe* were named a committee to work with the county welfare department on a new county medical plan.

Outagamie

Members of the Outagamie County Medical Society met January 19 at the Elks Club in Appleton with the Outagamie County Bar Association.

Guest speakers at the meeting were: *Dr. J. C. Griffith,* Milwaukee, past president of the State Medical Society, representing the medical profession, and Samuel Myers, Racine, representing the Wisconsin Bar Association. The newly revised "Interprofessional Code," was chosen as a topic; and after a discussion of this subject by the two guest speakers, a question-and-answer period was held.

In the business session which followed, it was decided that the Outagamie County Medical Society would not approve the giving of Salk vaccine through public clinics, and it was agreed that all vaccine would be given in the doctors' offices. It was decided that the charge for the vaccine would be that of an ordinary office fee, and those unable to pay would be authorized by the county or community nurse to receive the vaccine free of charge.

Polk

John Borup, Director of the Polk County Public Welfare Department, Balsam Lake, was the guest speaker at the January 19 meeting of the Polk County Medical Society held at St. Croix Falls Hospital, St. Croix Falls.

Mr. Borup discussed the present plans available for the medical care of those receiving county assistance, after which he led a round-table discussion regarding preliminary plans for co-operation between the doctors residing in the county and the Welfare Department.

Nineteen members of the society were present at the meeting.

Richland

The Richland County Medical Society's January 12 meeting was held at the Park Hotel and the Richland Hospital Library, Richland Center.

Eleven members were present to hear an address by *Dr. K. L. Puestow,* Professor of Medicine at the University of Wisconsin. He spoke on "Office Proctology for the General Practitioner."

Sauk

Robert E. Burns, M. D., Professor of Orthopedic Surgery at the University of Wisconsin Medical School, addressed members of the Sauk County Med-

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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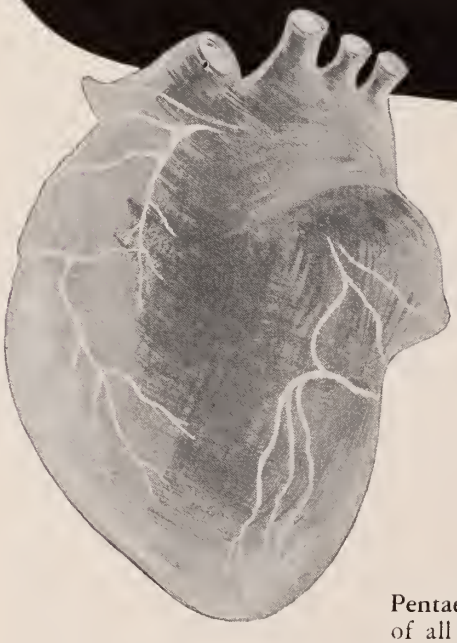

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SAMPLES and LITERATURE ON REQUEST

1. Platz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)
4. Russek and Assoc., Am. Jl. Med. Sciences (Jan. 1955)
5. Biegeleisen, Clinical Medicine (Oct. 1955)

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ical Society February 14. He discussed recent advances in surgery of the hip.

The meeting was held at the Warren Hotel in Baraboo, and dinner preceded the business meeting.

Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society met January 24 at the Club Midway, located near Independence.

Dr. Robert McMahon of the La Crosse Clinic was the guest speaker. He presented a discussion of a medical case.

A business meeting followed, and included the determining of a polio vaccine policy, and discussion of the possibility of changing the date of the society's monthly meeting.

Rock

Forty members attended the January meeting of the Rock County Medical Society held at the Hilton Hotel in Beloit on January 24. *Dr. John Talbot*, Madison, was the guest speaker and chose as his topic "Allergy."

The new president of the society, *Dr. F. M. Frechette*, presided at the meeting.

Walworth

The regular monthly meeting of the Walworth County Medical Society was held January 19 at the White Horse Inn in Elkhorn, and 16 doctors attended.

Robert L. McCarty, M. D., Milwaukee proctology specialist, was the guest speaker, and talked on "Lesions of the Large Bowel and Anorectal Area."

A business session followed the address, and election of officers was held. The following doctors were elected for 1956:

President—*Dr. G. A. Smiley*, Delavan
Vice-President—*Dr. J. E. Martin, Jr.*, Delavan
Secretary—*Dr. H. J. Werbel*, Delavan
Delegate—*Dr. E. D. Sorenson*, Elkhorn
Alternate Delegate—*Dr. E. D. Hudson*, Lake Geneva

Waupaca

Mr. Paul Doege, sales coordinator of Wisconsin Physicians Service, addressed 11 members of the Waupaca County Medical Society January 26 at the Hotel Marson in Clintonville. He spoke concerning insurance problems.

Election of officers was held, and the following now hold office: President, *Dr. W. G. Arnold*, Clintonville; Vice-President, *Dr. O. E. Larson*, Clintonville; and Secretary, *Dr. G. P. Dernbach*, New London.

Wood

Forty members of the Wood County Medical Society attended the annual meeting held recently at the Hotel Charles in Marshfield.

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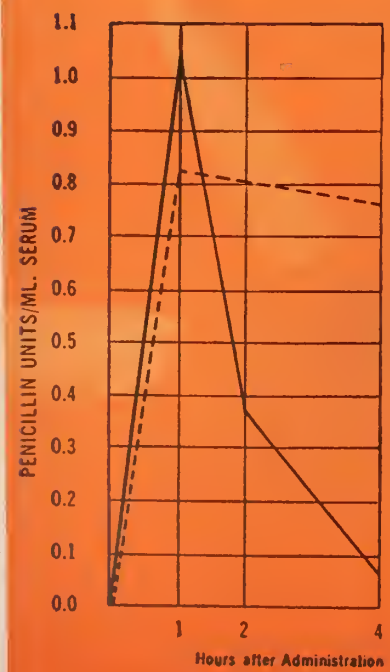

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Guest speaker at the meeting was *Dr. W. H. Heywood,* psychiatrist at the Marshfield Clinic, who talked on "The Psychological Aspects of Humor."

Election of officers was held during the business session.

Milwaukee Academy of Medicine

Dr. L. O. Jacobson, Professor of Medicine, University of Chicago, spoke to the Milwaukee Academy of Medicine at the University Club, Milwaukee, on February 21. He discussed "Recovery from Irradiation Injury."

A special clinic for the members of the Milwaukee Academy of Medicine was held on February 22 at the Milwaukee County General Hospital.

Milwaukee Oto-Ophthalmic Society

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held January 24 at the University Club in Milwaukee.

The guest speaker for the scientific program was *Francis J. Millen, M. D.,* who chose "Headaches" as his topic.

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society met at the University Club of Milwaukee on February 15.

The program included a business meeting, which was followed by a lecture on "A Mathematical Biologist Looking at Psychotherapy," given by guest speaker, Professor Nicholas Rashevsky.

Professor Rachevsky is chairman of the committee on mathematical biology, University of Chicago; founder and editor of the Bulletin of Mathematical Bio-Physics; and author of "Mathematical Theory of Human Relations."

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News Items and Personals

New Clinic Being Erected in Tomahawk

A new clinic will soon be completed at Tomahawk. It will have six consultation–examination rooms, an x-ray room, laboratory, waiting room, business office, and utility room. *Drs. D. F. Jarvis, E. C. Jarvis,* and *H. G. Adams* plan to occupy the new structure upon its completion.

Doctor Van Susteren Addresses P.T.A.

Dr. John E. Van Susteren, Sparta, presented the film, "Interim Report on the Salk Polio Vaccine," and led a question-and-answer discussion at a recent meeting of the West Primary Parent–Teachers Association. The meeting was held the afternoon of January 11 at the West Primary School in Sparta.

Menasha Club Hears Doctor Hutter

Dr. Adolph Hutter, Fond du Lac, discussed "Modern Concepts of Hardening of the Arteries" at the meeting of the Menasha Golden Age Club, which was held at the Jefferson School, Menasha, on January 11. The program was sponsored by the Wisconsin Heart Association. A movie entitled "Hardening of the Arteries" was also presented.

La Crosse Doctor Speaks to Businessmen's Club

Dr. Gunnar Gundersen, La Crosse, was the guest speaker at the regular business-luncheon meeting of the La Crosse Business Men's Club held at the Knights of Pythias Hall, La Crosse, on January 19. Doctor Gundersen is chairman of the board of trustees of the American Medical Association and a member of the council of the World Medical Association.

Staff Officers Named at Spooner Hospital

At the January meeting of the medical staff of the Spooner Community Hospital, *Dr. L. J. Olson,* Spooner, was named staff president. *Dr. F. H. Goetsch,* Spooner, was elected secretary–treasurer.

Staff rules, regulations, and by-laws were also adopted at the meeting.

Clintonville Hospital Staff Officers Named

Members of the medical staff of the Clintonville Community Hospital elected new officers at a meeting held February 21 at the Hotel Marson.

Dr. William McGinnis, Marion, was named president of the staff. He will succeed *Dr. William Arnold,* Clintonville, in this office.

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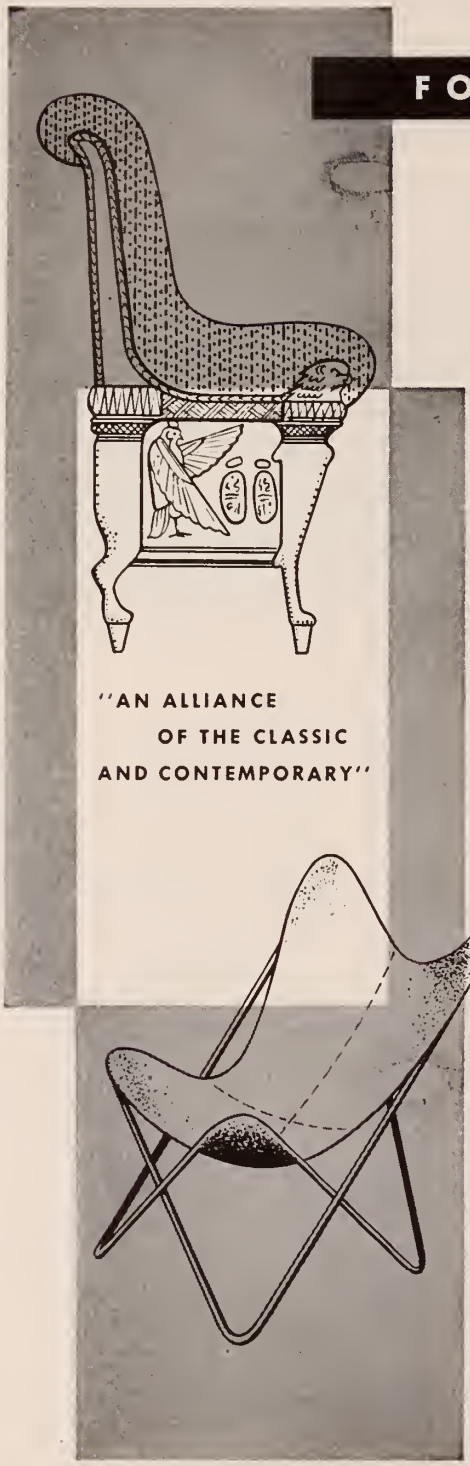

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Other officers elected at the meeting were *Dr. Harry Caskey*, Clintonville, vice-president, and *Dr. John Mulvaney*, Clintonville, secretary-treasurer.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Watzke Opens Office in Madison

Dr. D. F. Watzke, a native of Madison, has opened an office at 110 East Main Street, Madison, to specialize in ear, nose, and throat diseases.

Doctor Watzke graduated from the University of Wisconsin Medical School in 1947; interned at the University of Texas hospitals, Galveston; and served a three-year residency in otolaryngology at the University of Wisconsin hospitals, after which he spent two years as a captain with the Air Force medical corps at Fairbanks, Alaska. After completion of his military training, he served on the staff of the University of Wisconsin Medical School as an instructor in otolaryngology for 1½ years.

Doctor Maloof ICS Fellow

Dr. George Maloof, Madison, recently received his diploma as a fellow of the International College of Surgeons. Doctor Maloof has been in general practice, giving special attention to surgery, in Madison for the past 20 years.

Doctor Jackson Speaks at ICS Regional Meeting

Dr. Arnold S. Jackson, Madison, addressed the opening session of the Mid-Atlantic regional meeting of the International College of Surgeons, held at White Sulphur Springs, West Virginia, February 13–15. He also presented a scientific paper at the meeting. Doctor Jackson is president of the United States section of ICS.

Symposium on Anemia Held in Milwaukee

A symposium on anemia was presented at County General Hospital in Milwaukee, February 11, by members of the hospital staff and the Marquette University School of Medicine faculty.

Marquette faculty members who were speakers at the symposium included *Dr. F. W. Madison*, clinical professor of medicine; *Dr. A. V. Pisciotta*, assistant professor of medicine; *Dr. B. A. Waisbren*, clinical instructor in medicine; and *Dr. T. J. Greenwalt*, assistant clinical professor of medicine and also director of the Milwaukee Blood Center.

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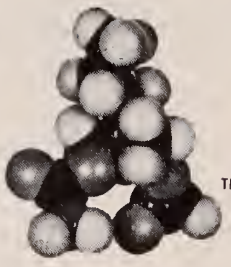

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C. L. Holmes, Wisconsin Rapids, to 444 East Main Street, Jackson, Tennessee.

Herman Tuchman, Madison, to 161 West Wisconsin Avenue, Milwaukee.

A. H. Hohf, Milltown, to 101 East Michigan, Urbana, Illinois.

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J. D. German, Clintonville, to Man Memorial Hospital, Man, West Virginia.

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R. M. Quetsch,** New York, New York, to Winnebago State Hospital, Winnebago.

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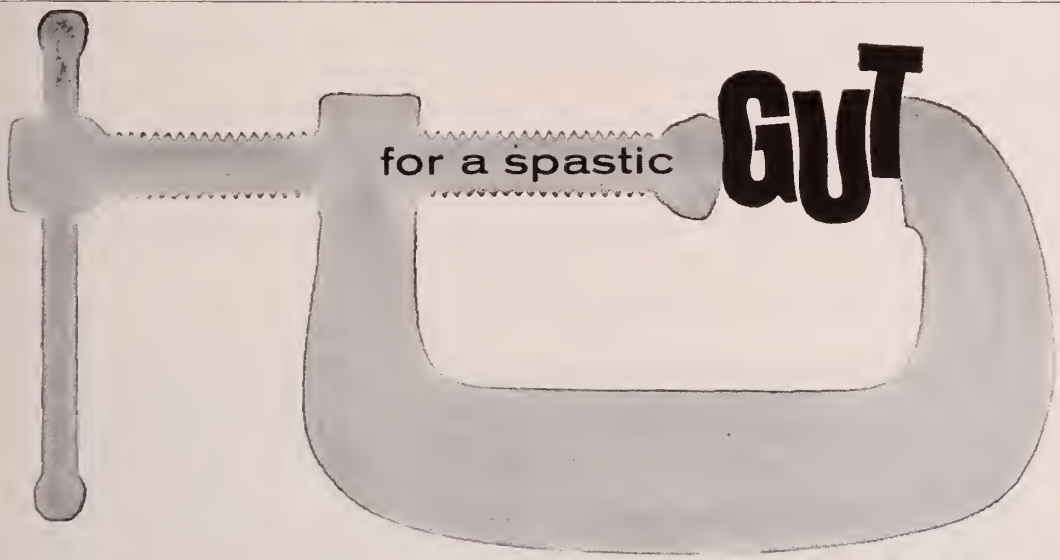

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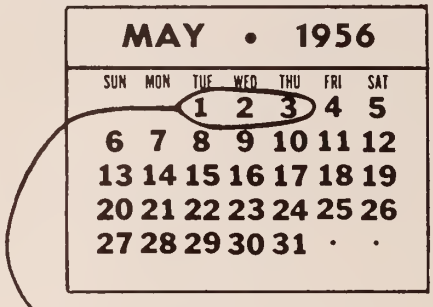

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OBITUARIES

Dr. Cyril G. Richards, 71 years of age, died at his home in Kenosha on January 31 following a long illness.

He was born in 1884 in Barbados, West Indies, and received his medical degree from Tufts College of Medicine at Boston in 1910. He was associated with the department of urology at Mayo Clinic, Rochester, Minnesota, in 1918, after which he returned to Boston. In 1922, he moved to Kenosha.

Doctor Richards was a specialist in urology. He was a member of the State Medical Society of Wisconsin, a member and past president of the Kenosha County Medical Society, and a member of the American Medical Association. He also held membership in the American Urological Society, the American College of Surgeons, the North Central Branch of the American Urological Society, the Chicago Urological Society, the International Academy of Medicine, and the Wisconsin Urological Society, of which he was a past president.

He served on the staffs of St. Catherine's and Kenosha hospitals, Kenosha, and served as a consultant at Willowbrook Sanatorium, Kenosha. He was a former member of the Salvation Army Advisory Board and the Kenosha Police and Fire Commission, and during World War II served as chief of medical civilian defense.

Survivors include his widow, Eileen; three sons, Dr. John N., Killeen, Texas, Paul H., Kenosha, and Charles J., Kenosha; and two daughters, Mrs. Thomas Walker and Mrs. Dennis Buell, both of Kenosha.

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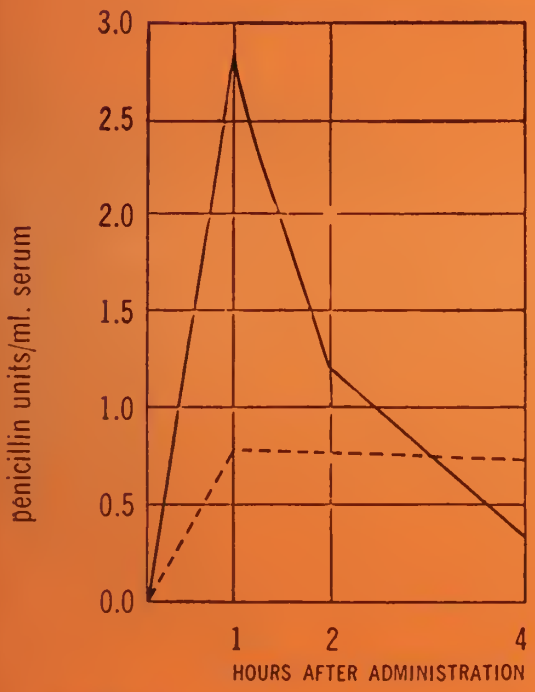

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1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

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Where "The Nuts Came Off the Buggy"

There are nearly 80 Blue Shield plans in the United States. Each serves a limited area with its own benefits and fee schedules. Since each plan is an arm of the medical profession in its own area, the variations in coverage within Blue Shield nationally are wholly natural and, to a point, realistic. Recently, however, certain employers with branch offices in many states have insisted on the purchase of insurance programs which provide uniformity of coverage to all employees no matter where they work. The following remarks on this problem were made by Lewis G. Hersey, Salt Lake City, executive director of the Medical Service Bureau of the Utah State Medical Association, at the 1955 annual meeting of Blue Shield plans:

". . . The executives of national accounts, and labor unions, national in scope, have no concern for the limited area served by each of our plans. Let's take something tangible such as an automobile. Can you imagine for one minute the purchasing agent of Procter and Gamble wanting to place a fleet order with one of the major automobile manufacturers for a specified type of panel truck to be painted black and white, with a V–8 type engine, automatic transmission, taxicab-type springs, and tires of a specific size. Then imagine that the automobile manufacturer in discussing the potential order tells Procter and Gamble that for sake of economy he will be glad to make delivery from eight assembly plants throughout the country, but that in California they have no black or white paint, so the panel trucks will be painted red; that from the Atlanta assembly plant the cars will be delivered with a straight 6–cylinder motor; in Kansas City the cars will have standard transmissions, in Seattle, standard springs, and in Utah, there is a real problem—there the cars will be delivered with no tires at all. Gentlemen—right there is where the 'nuts came off the buggy.' I am sure that the purchasing agent of Procter and Gamble would quickly seek a new supplier for a thousand automobiles. The buyer in this instance wants uniformity—he has to keep cost figures—he wants uniformity of equipment for a given job. He is the buyer—and as such is in the position to dictate the specifications of the product he is interested in purchasing. In this business of ours many national employers and nationwide unions not only seek, but demand uniformity of coverage for their personnel whether they are located in New York, Chicago, or the Pacific Coast, and I need not mention one example—for you each have one of your own. We established a vehicle to provide such potential groups with this uniformity known as Health Service and Medical Indemnity, and while on the hospital side of the picture such uniformity can be offered, on the professional side we fall quite short of being able to do the job as well—because it is indemnity— and a number of Blue Shield plans are unable or unwilling to 'take off' such underwriting in their areas. With limited capital and surplus—our vehicle is brought almost to a standstill."

Mr. Hersey points out that Blue Shield's future service to more people is definitely limited unless it provides a common denominator for national accounts. This means uniformity of coverage, although not uniformity of rates. In other words, Mr. Hersey said, Blue Shield must offer service benefit plans. Wisconsin's experiment in payment of the "customary, usual and reasonable" charges of the physician may provide a key to the solution of this problem. Through it, uniform benefits could be provided, but physicians in each area would be paid their usual charges.

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CORRESPONDENCE

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

Gentlemen:

Congratulations to the author of the article, "What About Your Medical Assistants?" which I read with interest since I am a medical secretary and am sincerely proud of this profession. My only hope is that the doctors throughout the state who have not heretofore taken the time to consider their medical assistants will carefully study this article and urge their employees to join the Wisconsin State Medical Assistants Society.

This society was organized in June, 1955, and to date we have 240 charter members. Our chief project during the coming year will be to develop more local or county medical assistant societies. Without the cooperation of the doctors, this cannot be accomplished. We would like the privilege of appearing before the county medical societies to tell the doctors more about our organization—how they will benefit from having their medical assistants participate in such an organization, what they could accomplish as a local or county group, etc. We also hope to develop an insurance program, placement bureau and an educational training program for medical assistants. Many doctors say they've never heard about our group but will they take the time to hear about it? We hope they will since it means so much to us. We appreciate the cooperation and assistance we have had from the State of Wisconsin Medical Society and the Council on Medical Services but we need the help of all Wisconsin doctors if the Wisconsin State Medical Assistants Society is to be 100% successful.

Recently, Miss Alice Budny, president of the WSMAS, and I were in Kansas City, Kansas, attending a meeting to draw up the constitutional framework for creating a national organization for medical assistants. Eighty-nine girls from sixteen states were present. After the constitution and by-laws are printed, they will be sent to the state groups for ratification before being submitted to the American Medical Association for approval. We are proud to announce that the first meeting of the American Association for Medical Assistants will be held in Milwaukee, Wisconsin!

Doctors, if you haven't read the article, "What About Your Medical Assistants?" in the October Wisconsin Medical Journal, please do so now. We need your support!

Yours sincerely,

(s) LOIS M. PLUCKHAN
President-Elect

UAW-CIO

INTERNATIONAL UNION, UNITED AUTOMOBILE, AIRCRAFT AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA

Gentlemen:

I am gratified to see that you have reproduced in full in your January, 1956 "Medical Forum" my letter to the Michigan Commissioner of Insurance, concerning Blue Cross premiums in this state. I would hope that this communication would make the members of the medical profession in Wisconsin, and others who read your issue, more aware of the fact that we who represent the worker and his family—an important group of consumers of health service—are being quite responsible in trying to make the present system of voluntary health insurance work.

I appreciate your willingness to present labor's side of the story to the medical profession in your state.

Sincerely yours,

(s) WALTER P. REUTHER
President

AMERICAN MEDICAL ASSOCIATION

Gentlemen:

The American Medical Association deeply appreciates the action of the State Medical Society of Wisconsin in sending Mr. Robert B. Murphy to Washington to appear before the Senate Finance Committee relative to H.R. 7225. It is our understanding that your witness did a very nice job in placing before the Senate Committee pertinent facts relative to the provisions of this bill.

Sincerely yours,

(s) GEORGE F. LULL, M. D.
Secretary and General Manager

UNITED STATES SENATE
COMMITTEE ON FINANCE

Gentlemen:

Thank you for sending me copies of the resolution adopted by the Council of the State Medical Society of Wisconsin relating to the social security revision bill, H.R. 7225.

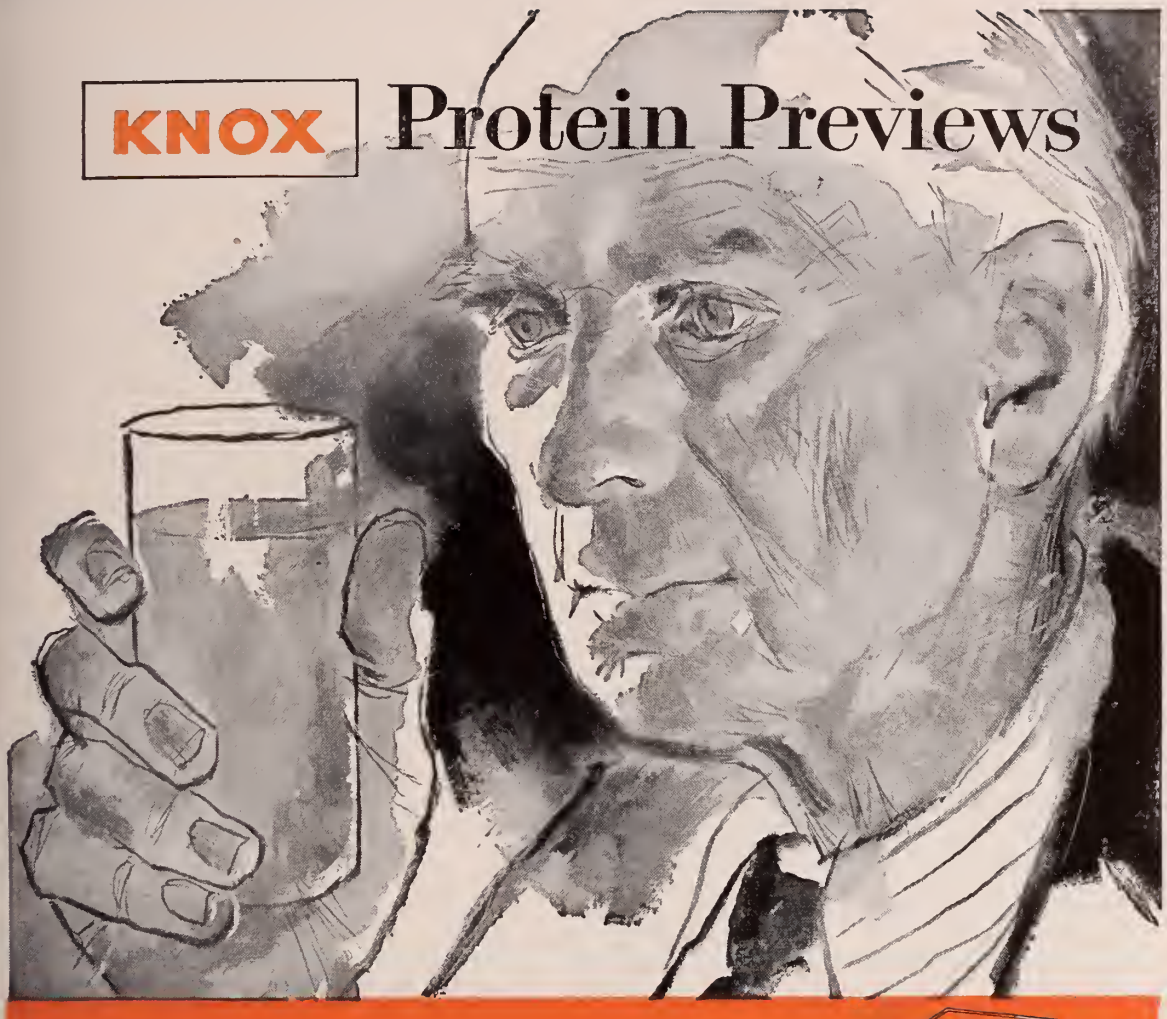
I am taking the liberty of inserting your resolution in the printed record of the hearings on H.R. 7225 following the oral testimony of your attorney, Mr. Robert B. Murphy.

With kindest regards, I am

Cordially yours,

(s) HARRY F. BYRD
Chairman

KNOX Protein Previews



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The value of fat in human nutrition was emphasized in a recent study[2] comprising 200 patients incapable of receiving adequate nourishment. For periods of 1 to 30 days, these patients were given supplementary fat alimentation by vein in the form of fat emulsion containing "essential" as well as other fatty acids. The result was typically a marked increase in weight and more positive nitrogen and potassium balances.

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1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

The nutritional statements in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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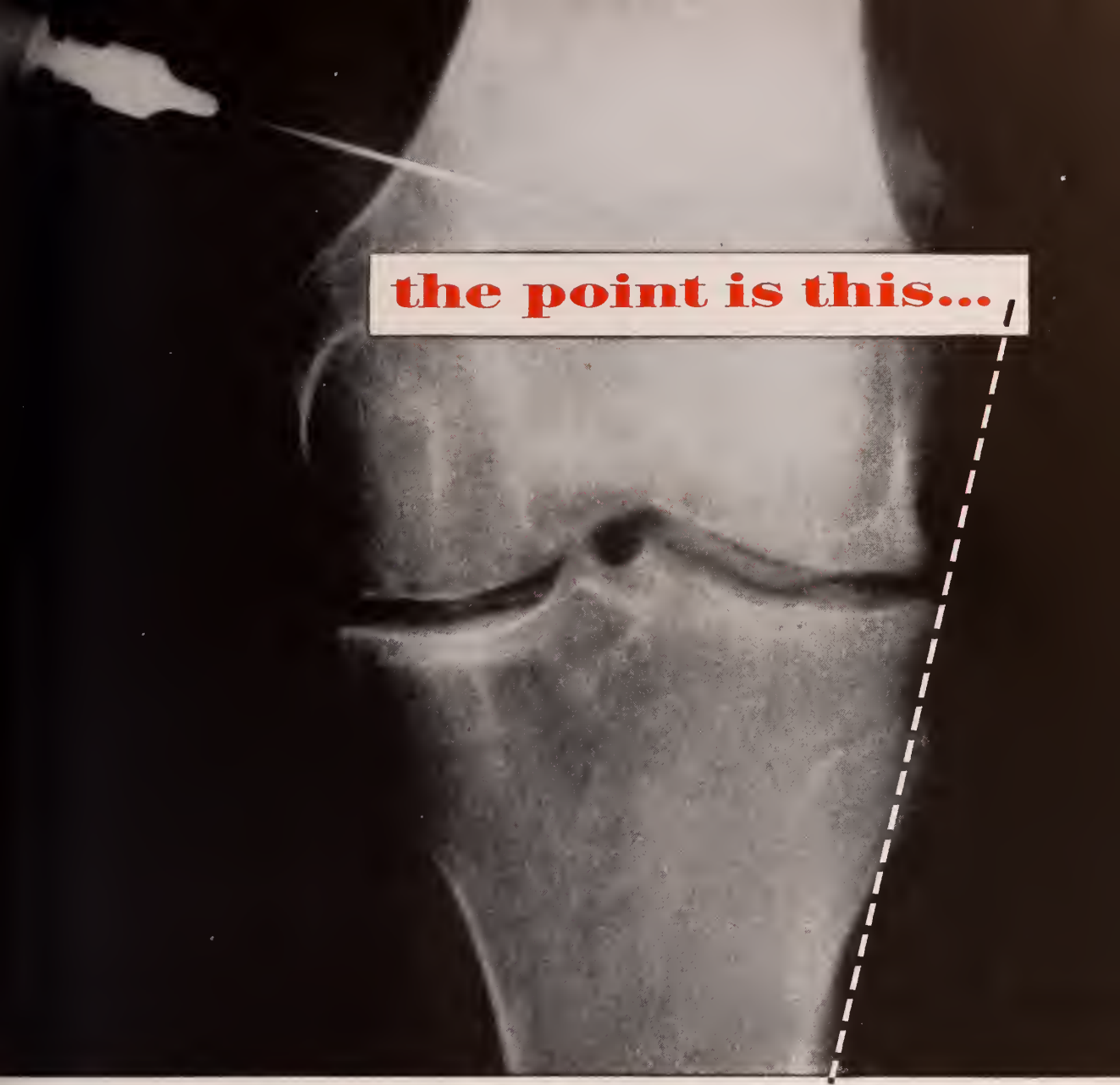

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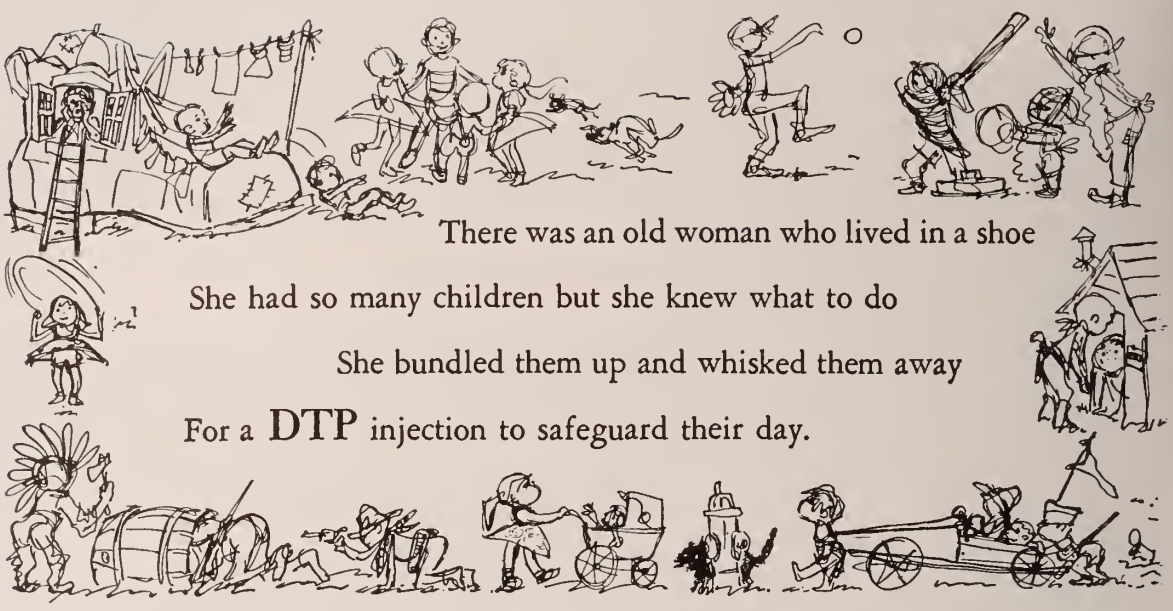

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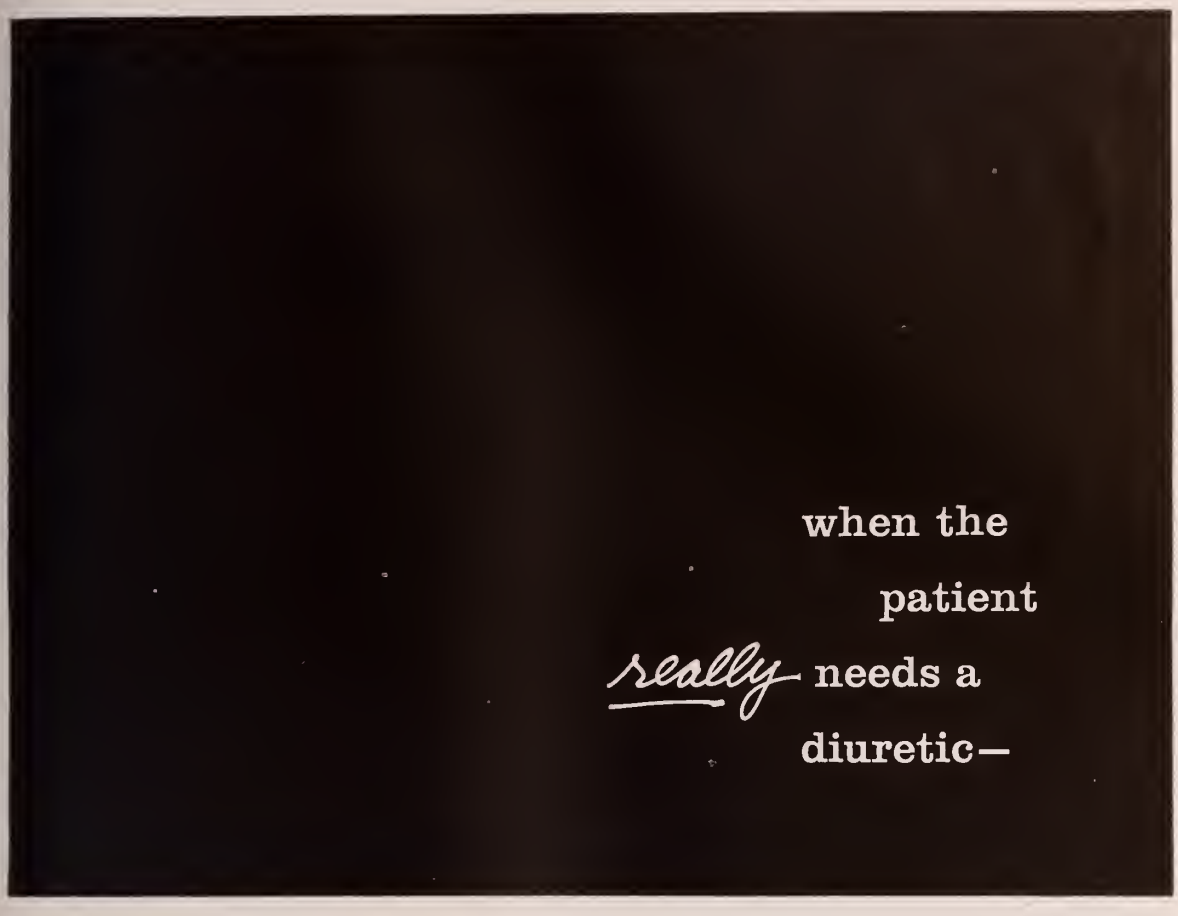

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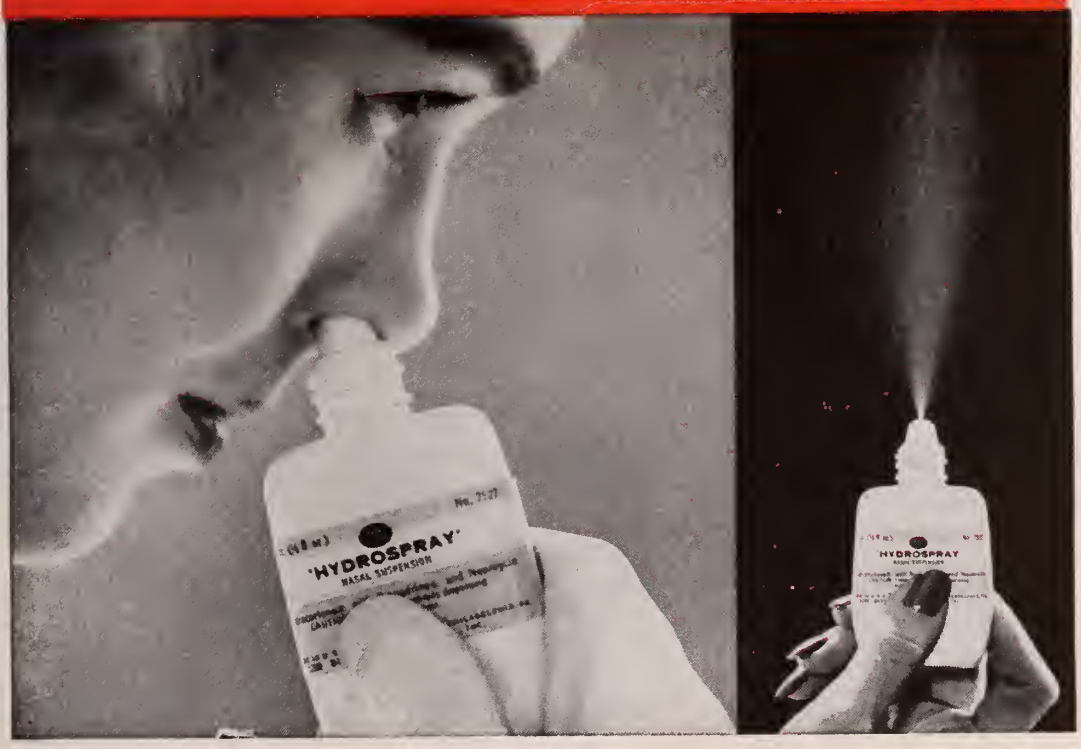

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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

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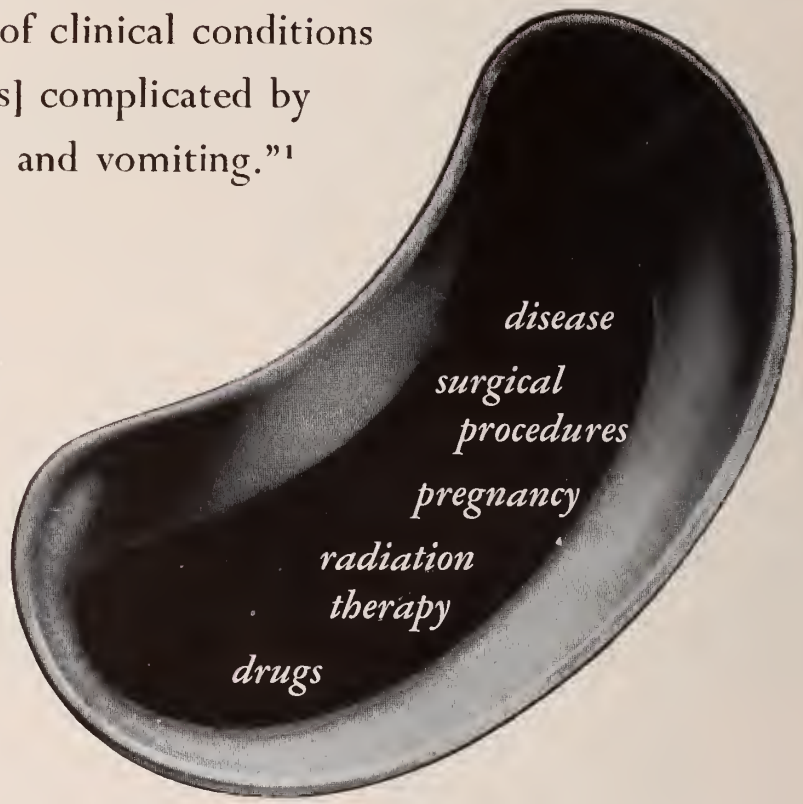

1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

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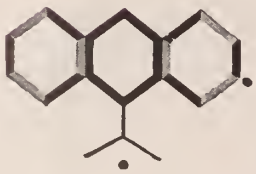

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	258, 259
American Meat Institute	348
Ayerst Laboratories	331
Baker Laboratories	256
Barr X-Ray Company	263
Bayer Company	359
Benson Optical Company	333
Brown and Williamson Tobacco Corp.	356
Burroughs Wellcome & Co., Inc.	328, 329
Canada Dry	350
Ciba Pharmaceutical Products	339
Continental Baking Company	262
Cook County Graduate School of Medicine	350
Davies, Rose & Co. Ltd.	337
Doerflinger Artificial Limb Co.	354
Endocrine Laboratories	252
Evron Company, Inc.	330
Gyne-Cytology Laboratory	354
Hotel Schroeder	332
House of Bidwell	253
Hurley X-Ray Company	253
Keeley Institute	339
Kennedy-Mansfield	335
Knox Gelatine	345
Lakeside Laboratories	252, 263, 353
Lederle Laboratories	302, 303
Lilly, Eli and Company	266
Mallard, Incorporated	342
Mallatt Pharmacy	335
Mather Pharmacy	335
Mayo Clinic and Foundation	354
Mead Johnson and Company	261, 363
Medical Protective Company	350
Milwaukee Sanitarium Foundation, Inc.	364
National Drug Company	352
New York Polyclinic	263
Orthopedic Appliance Company	340
Parke, Davis and Company	250, 251
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	346, 361
Physicians Casualty Association	362
Professional Business Service	310
Quincy X-Ray and Radium Laboratories	253
Rennebohm's	335
Rogers Memorial Sanitarium	364
S. and L. Signal Company, Inc.	263
Sacred Heart Sanitarium	340
St. Croixdale Sanitarium	253
Schering Corporation	254, 255, 264, 265
Schmid, Julius, Inc.	257
Searle, G. D. and Company	325
Smith, Kline & French Laboratories	358
Sharp and Dohme	260, 351, 355
Shorewood Hospital Sanitarium	335
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp.	357
Time Insurance Company	308
Tutag, S. J., and Company	334
Upjohn Company	263, 349
Wallace Laboratories	338
Winthrop Laboratories	336
Wisconsin Neurological Foundation	327
Wyeth	332, 341

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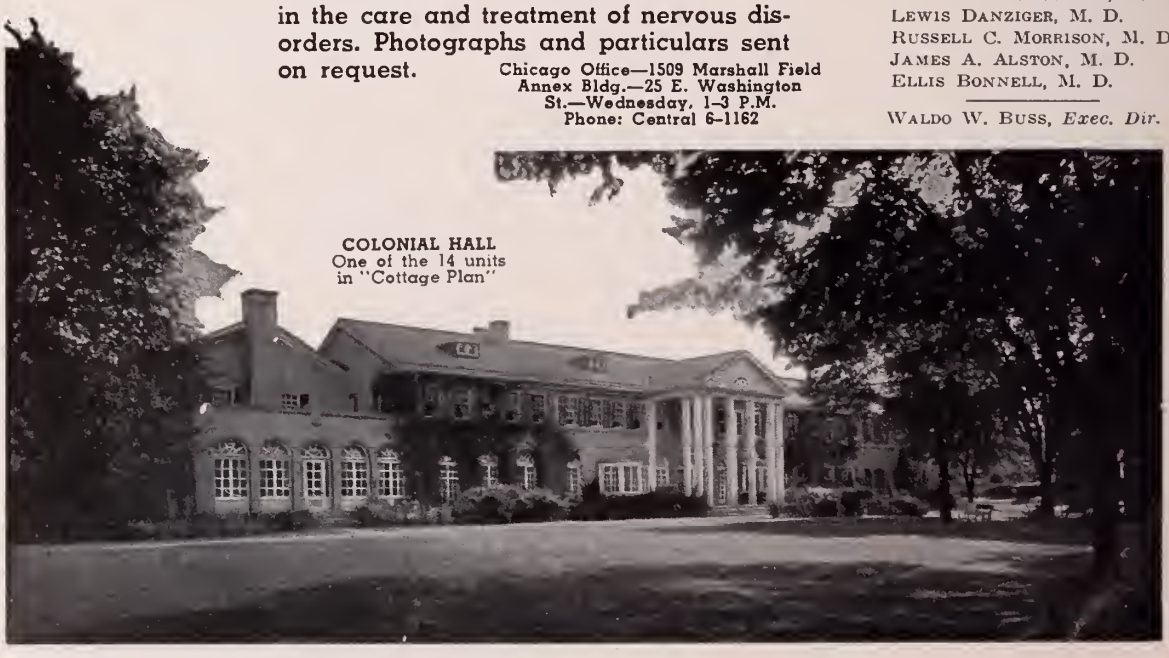

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TABLE OF CONTENTS

Scientific Articles

	Page
The Role of Regional Anesthesia in Surgery, Obstetrics, Diagnosis, and Therapy, by John J. Bonica, M. D.	387
Comments on Treatment	396
Congenital Bilateral Bony Atresia of the Posterior Nares, by Sidney K. Wynn, M. D., and James P. Conway, M. D.	428
Gamma Globulin in Treatment of Epidemic Infectious Hepatitis, by Fred J. Ansfield, M. D.	431
Tuberculin Tests: Their Importance in a State Program of Tuberculosis Control, by Helen A. Dickie, M. D.	433
Participation of Physicians in Private Practice in Basic Tuberculosis Control Procedures	437
Treatment of a Five-Pound Infant with Congenital Esophageal Stenosis, by Richard H. Segnitz, M. D.	477
Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists	452
Clinicopathologic Conference	455
The Effectiveness of Salk Vaccine in Wisconsin	462

Miscellany

	Page
1956 Annual Meeting	397
Facts About Wisconsin Physicians Service	464
Society Proceedings	470
News Items and Personals	476
Third and Twelfth Districts News	479
Society Records	484
Obituaries	486
Correspondence	489
Physicians' Exchange	492
Index to Advertisers	494

Editorials

The President's Page	469
"Cultists, Expediency, and Responsibility"	467
A Valuable Program	468
Up and Still Upward	468

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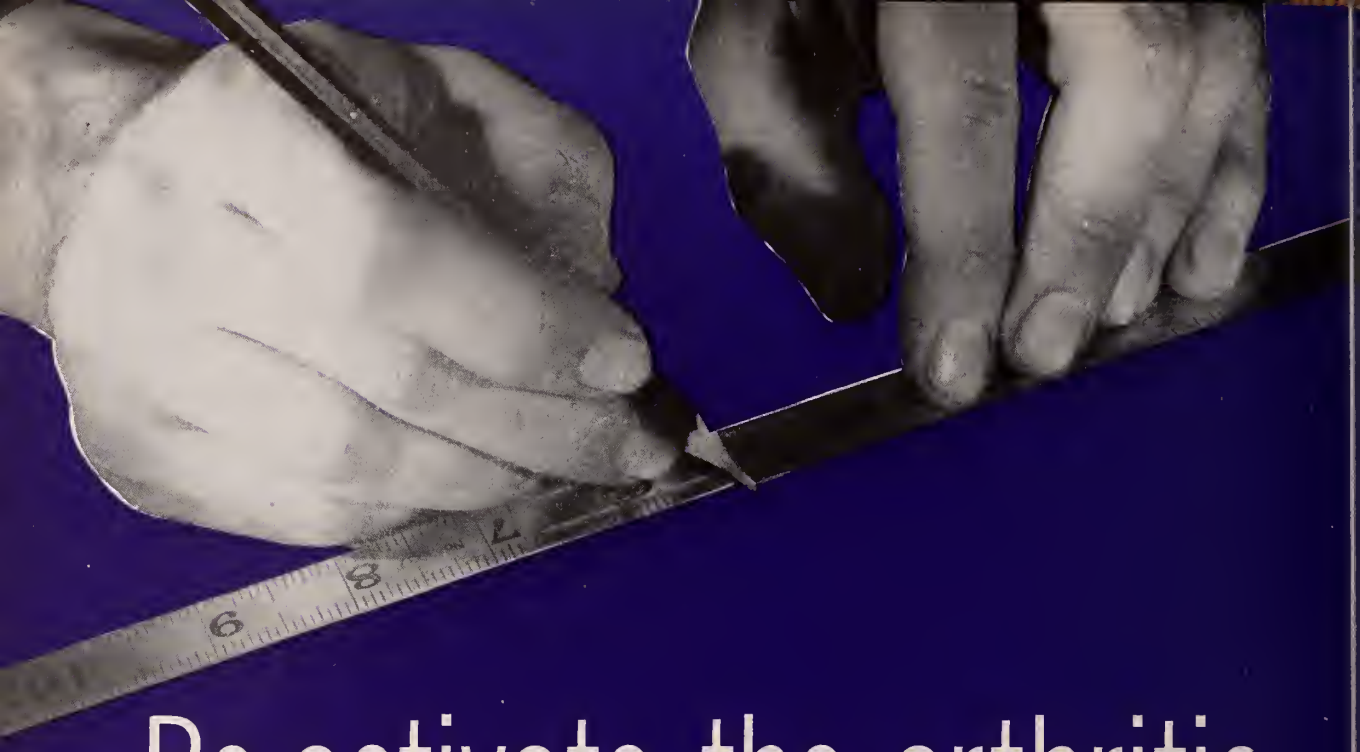

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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

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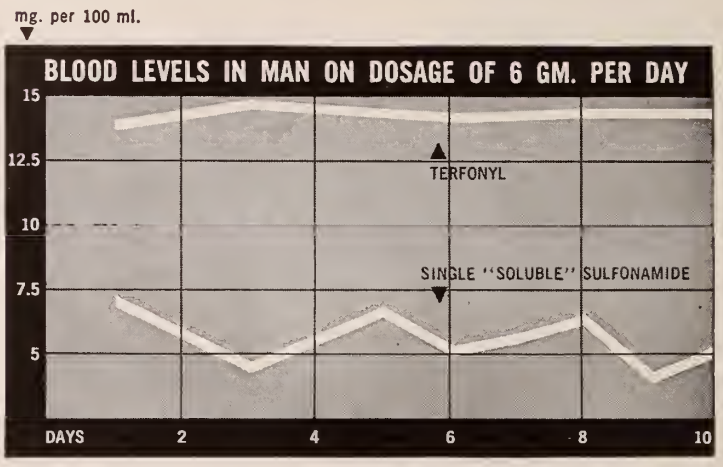

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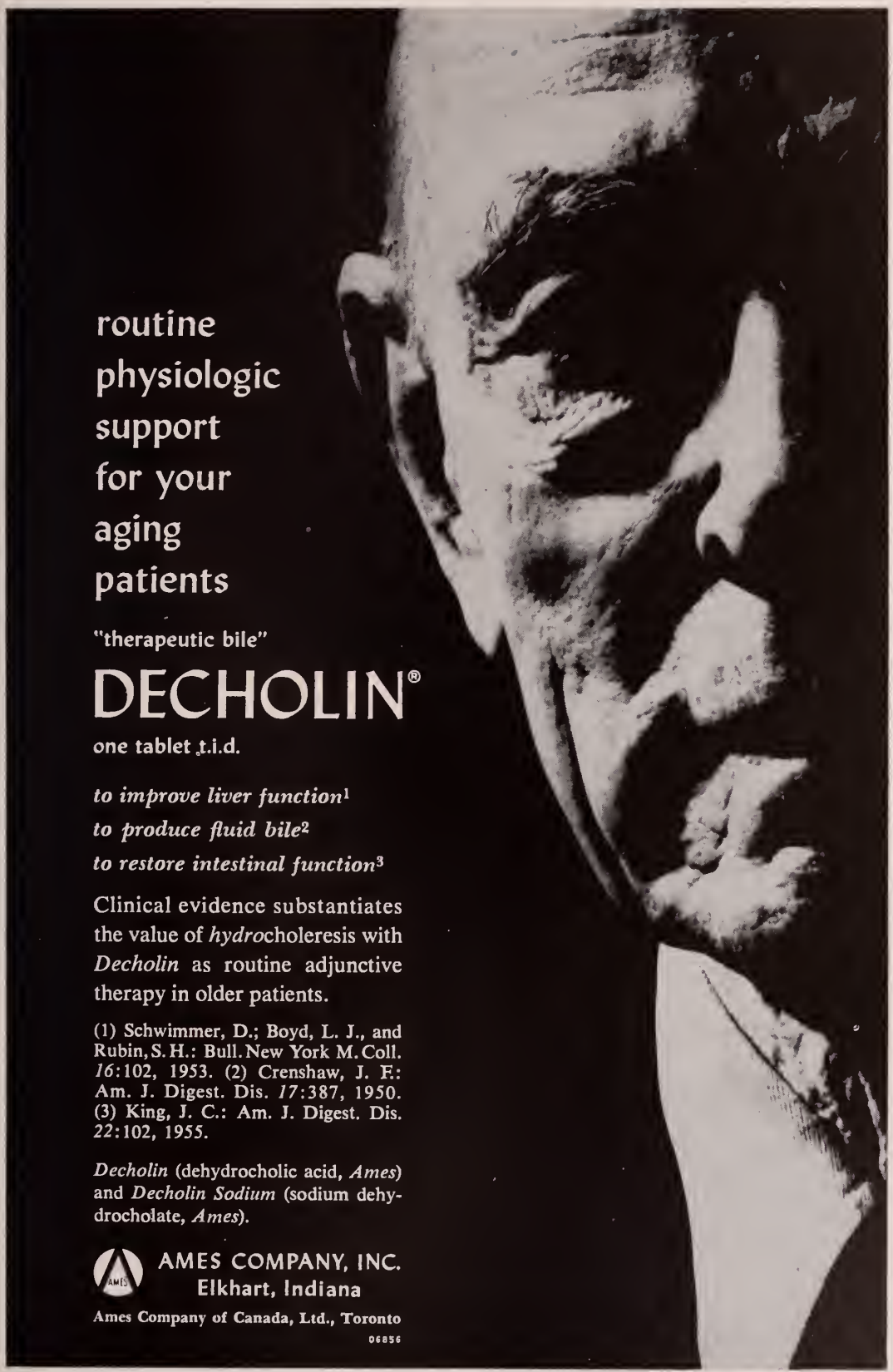
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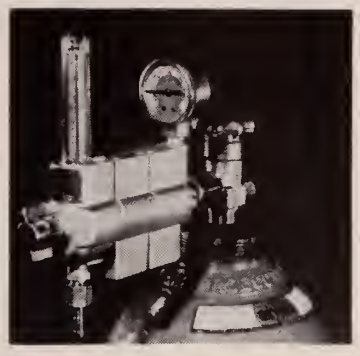

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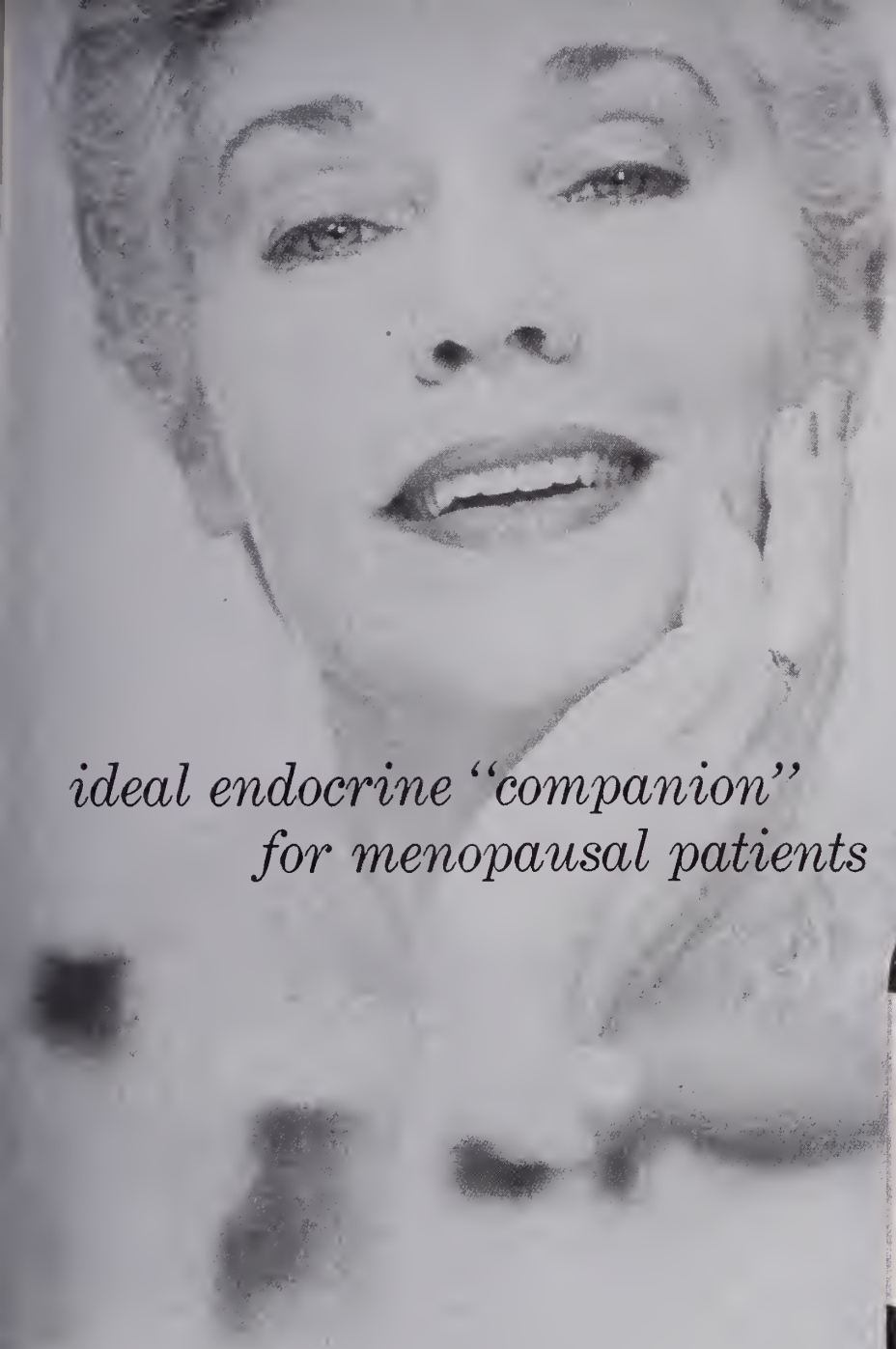

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The Role of Regional Anesthesia in Surgery, Obstetrics, Diagnosis, and Therapy*

By JOHN J. BONICA, M. D.**
Tacoma, Wash.

IT IS the purpose of this discussion to clarify the present status of regional anesthesia and to indicate its proper role in surgery, obstetrics, diagnosis, and therapy. Since mine is the introductory portion to the subject, I plan to limit my discussion to generalities of several aspects of regional anesthesia.

Although it would seem hardly worth while to discuss this subject in an era when the magic mixtures of curare and other muscle relaxants and the intravenous barbiturates dominate the scene in American anesthesiology, I believe it is a very timely topic for reasons which will become apparent. A re-evaluation of the method is particularly important in the light of present trends in anesthesiology and since there are differences of opinion among anesthesiologists regarding it. It is especially important for physicians who are not anesthesiologists to realize and appreciate the clinical usefulness and advantages as well as the limitations and disadvantages of this method of anesthesia, not only for operative procedures, but also as a diagnostic and therapeutic adjunct.

Paradoxically, with the advent of the specialist in anesthesiology, there has been a marked decrease in the use of regional anesthesia, particularly in surgery. Thus, it is noted that during the past 15 years, when anesthesiology has progressed more rapidly than any other branch of medicine and the number of physicians who have entered the specialty has increased tenfold,[1] the use of regional anesthesia has become rather limited in most American surgical clinics. There are probably several reasons for this trend, not the least important of which is the high standard attained in general anesthesia. Development of many highly trained physicians, improvements in techniques and agents, better knowledge of the alterations in respiratory physiology and other body functions produced by general anesthetics and how to minimize them, together with introduction of certain adjuncts, particularly curare and its congeners, have made general anesthesia more suitable for poor risk patients. In addition, in circumstances where formerly a trained anesthesiologist was not available, poor risk patients were operated upon with regional anesthesia administered by the surgeon with an anesthetic technician in attendance. Today in such circumstances the use of Pentothal for induction and curare or similar drugs for relaxation by the less skilled technician affords good operative conditions and what appears superficially as good anesthesia, although often it does not contribute to the physiologic economy of the patient.

But there are other reasons for the decrease in the use of regional anesthesia. In the excitement of taking part in the many developments that have come about and becoming acquainted with them, anesthesiologists have neglected this method. In recent years teachers have justifiably emphasized the great importance of general anesthesia, but in doing so they have slighted regional techniques. Perhaps this may be due to the fact that they themselves have misconceptions about regional anesthesia because of

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inexperience with it. One of the authors of a recently published textbook on anesthesiology states that successful results with brachial plexus block occur in less than 75%, even in the hands of the most skillful anesthesiologists.[2] This statement seems to indicate that the author never learned the technique of brachial plexus block properly, and/or he has done very few such blocks. Certainly if the teacher lacks confidence in the method the student will never accept it. Because of this emphasis made on general anesthesia, many anesthesiology residents finish their training with little or no experience with regional blocks. In their practice they feel uncertain about them; and rather than risk a failure, they use narcosis instead. The confidence in the regional anesthesia method, which should have been instilled during their training, is lacking; and they do not become proficient with it. This is unfortunate, indeed, because the well-trained anesthesiologist should be able to administer regional anesthesia equally as well as general, not only because the former is of value in surgical and obstetrical patients, but also because the anesthesiologist is being called more and more to aid his colleagues in the diagnosis and therapy of certain diseases with nerve blocks.

Advantages of Regional Anesthesia

While admittedly the administrator is more important than the method, technique, or drug in obtaining satisfactory results, we believe that regional anesthesia, *when properly administered and completely effective for the duration of the entire operation,* in selected cases offers certain advantages to the patient, surgeon, and anesthesiologist, not to be had with general anesthesia. Although these advantages have been long recognized and are appreciated by all those who have had sufficient experience with the method,[3-8] they need to be mentioned because they are being ignored or discounted by those who have not used the method sufficiently. Before I begin to extoll the virtues of this method, I want to state that I consider general anesthesia, and particularly inhalation, the foundation of anesthesiology. In our departments we employ general anesthesia in 55% of the patients. Moreover, our residents do nothing but general anesthesia for the first six months of their training.

ADVANTAGES TO THE PATIENT

The outstanding advantage of regional anesthesia is that it taxes the physiologic economy of the patient less than general anesthesia. When *properly administered,* it involves only a limited area without interfering with the function of other organs or structures. By producing a transient "physiologic section" of the nerves supplying the region to be operated, it effects a specific and complete sensory blockade and thus prevents pain and other noxious impulses produced by accidental and surgical trauma from reaching the central nervous system.[9] Moreover, regional anesthesia, by completely blocking off afferent impulses, obviates abnormal reflex mechanisms which are often the source of marked alterations in cardiac and respiratory functions and of initiating the stress syndrome. In addition, there is complete muscular paralysis; but unlike that produced by curare and its congeners, it is limited to the area of operation. Of course, with high subarachnoid and peridural blocks there is involvement of some respiratory muscles, but even with these the diaphragm, the upper intercostals, and the accessory muscles continue to function. Complete sympathetic blockade of the blocked region results in maximal vasodilatation, which is of value in certain conditions.

Since the central nervous system is not involved, the respiratory, vasomotor, and other important medullary centers are not depressed and thus cardiovascular, respiratory, and other homeostatic reflex mechanisms are not interfered with to the same degree as occurs with general anesthesia. These considerations are important in any patient, but particularly in the individual in poor physiologic condition — the so-called poor risk patient—who may not tolerate the stress imposed by general anesthesia. Patients who present complicating conditions such as cardiac, pulmonary, hepatic, and renal diseases; diabetes; cerebrovascular disorders; chest and head injuries, etc., are usually able to withstand necessary surgery with regional techniques better than with deep narcosis. The method under discussion is particularly applicable in older patients, not only because they are disturbed less psychologically, but it produces less disturbances in physiologic processes which are already overburdened with the effects of aging. These statements do *not* apply to extensive subarachnoid, peri-

dural, paravertebral, or splanchnic block since these techniques, by interrupting many vasoconstrictor fibers, also interfere with homeostasis.

These important advantages, long recognized by most physicians, have been discounted in recent years by some anesthesiologists who contend that the advent of muscle relaxants and other adjuncts have made general anesthesia as safe for the patient as regional anesthesia. While it is true that the aforementioned developments in anesthesiology have markedly decreased the disparity in the physiologic alterations produced by the two methods, they have not completely eliminated it. I could cite a great deal of clinical and experimental work in support of this statement, but I shall limit it to the more important evidence adduced in recent years which indicates that: 1. general anesthesia is not as innocuous as some anesthesiologists would lead us to believe, and 2. regional anesthesia produces less morbidity and mortality than general anesthesia.

As it is well known, a multiplicity of homeostatic mechanisms continually adjust the function of the heart, peripheral circulation, respiration, and other physiologic processes; and whenever any stress which tends to alter these processes is placed upon the body, compensatory mechanisms are brought into play. Unfortunately, general anesthesia and some forms of regional anesthesia, such as extensive spinal, peridural, or splanchnic blocks, even when administered expertly, interfere with many of these homeostatic mechanisms so that some of the patients cannot readily compensate. This is especially true in old patients or those who have complicating diseases because these factors in themselves produce a physiologic impairment.

Recent studies indicate that general anesthetic agents impair the efficiency of the myocardium[10-12] and produce a rise in central venous pressure, which may be an indication of cardiac incompetence.[13] Brewster[10] has demonstrated that ether, which has long been considered as innocuous to the heart, produces depressant effects on the myocardium. It has also been shown that the ultra short-acting barbiturates have a direct weakening effect on the myocardium with a consequent reduction of cardiac output,[14, 15] particularly when large doses are used and/or when they are used over a long period of time.[16] This is particularly evident during and immediately following the rapid introduction of these agents into the blood stream. The "shotgun" technique of administering Pentothal and a muscle relaxant for induction with rapid intubation as practiced in some quarters often results in marked hypotension,[17, 18] which may enhance the deleterious effects of reflexes initiated by the intubation.[19]

It has been shown by Zweifach, Hershey, and their associates[12, 20-24] that general anesthetic agents also interfere with the peripheral homeostatic mechanisms. Specifically, they interfere with vasoconstriction and vasomotion, with the reactivity of arterioles, meta-arterioles, and precapillary sphincters to epinephrine, and with the elaboration of the vasoactive substance. These effects result in vasodilatation of all of the capillary bed with the production of stasis, decrease in capillary outflow and venous return, increase in capillary permeability, and consequent loss of circulatory blood volume. Although ether has the most pronounced deleterious effects on the peripheral circulation, all general anesthetic agents exert this influence. Moreover, these deleterious effects become more marked as the depth of anesthesia is increased, so that during deep narcosis all general anesthetic agents produce a profound depression of the peripheral homeostatic mechanisms. This may be considered as laboratory evidence which supports the clinical adage that 15 minutes of anesthesia in third plane produces as much physiologic disturbance as 2 hours of first plane anesthesia.[25] Zweifach *et al.* further demonstrated that procaine (regional) anesthesia produced no impairment in vascular response to stress, and survival following hemorrhagic shock was greater in experiments in which the animal was desensitized locally by infiltration of procaine without subjection to general anesthesia.

In addition to these direct deleterious effects, general anesthetics produce cardiovascular disturbances by enhancing abnormal reflex phenomena.[26-33] With the increased clinical use of the electrocardiogram and cardioscope, it has become more apparent that stimulation of any sensory nerve in the body may initiate reflexes that may result in marked alteration in blood pressure and cardiac rhythm, and in even cardiac arrest.[26, 33] These reflexes, which are more

prone to occur during light surgical anesthesia, are the result of hyperactivity of the autonomic nervous system and sensitization of the cardiovascular apparatus. General anesthetic agents exert this effect particularly on the specific tissue of the heart, which, as is well known, is widely distributed in the auricles and ventricles and normally has the capacity of forming stimuli independently of any extrinsic neurogenic influences.[32] This automaticity, which is expressed in rhythmic contractions, is not interfered with if the heart is normal and *not* under the influence of general anesthesia. However, anesthetic agents, like disease, depress the function of the specific tissue so that the heart becomes vulnerable to abnormal extrinsic neurogenic stimulation. This "sensitizing" effect of general anesthetic agents is further enhanced by hypoxia and hypercarbia—factors which exist much more frequently with narcosis and relaxants than with regional techniques. These factors have been invoked as the most frequent causes of disturbances in cardiac rhythm and cardiac arrest during anesthesia.[9, 33, 34] Since regional anesthesia produces complete sensory block, it is impossible to initiate such reflex phenomena in a surgical field that has been adequately blocked off with this method.

As previously mentioned, regional anesthesia protects the central nervous system against noxious impulses that may have deleterious effects. That such is not the case with general anesthesia has been shown by recent studies with the electroencephalogram.[35, 36] These studies reveal that sensory stimulation in light surgical anesthesia produces a generalized increase in cortical activity. Moreover, these afferent discharges to the cerebral cortex still occur after spontaneous cortical activity has been suppressed. Since spontaneous activity does not cease until the patient is in very deep surgical anesthesia, it is apparent that noxious impulses continuously bombard the central nervous system during narcosis. This is objective evidence which supports George Crile's concept of anoci-association proposed half a century ago.[37] Bombardment of the central nervous system by noxious impulses originating from the site of accidental or surgical trauma cannot be considered as a normal condition. And while patients in good condition may be able to tolerate such insults, it does not mean that they are not deleterious to the body.

Finally, it must be remembered that general anesthetic agents exert their effects by interfering in some unknown way with cellular metabolism. In actuality, then, these drugs produce a cellular intoxication which disturbs acid-base, electrolyte, and fluid balance. The more profound the anesthetic, the greater these disturbances. The introduction of curare and other muscle relaxants must be considered as one of the greatest milestones in anesthesia because they make deep anesthesia unnecessary and thus minimize these effects. However, the muscular relaxation of the surgical field produced by these agents, while very adequate for the surgeon, exacts a high price from the patient in the form of inadequate respiration or complete loss of this function. Although these effects can be counteracted by assisted or controlled respiration, it should be appreciated that ventilation with these methods alters cardiopulmonary hemodynamics, which may have untoward effects.[38, 39] Moreover, not infrequently these maneuvers are done improperly, so that hypoxia and hypercarbia occur with their undesirable effects. It should be noted that marked hypotension secondary to extensive subarachnoid and other vertebral blocks also produces hypoxia and hypercarbia.

That the aforementioned effects are not merely theoretical, but are actually deleterious is attested by examining mortality statistics. There are many reports which clearly indicate that regional anesthesia is safer than general anesthesia, but I will cite only a few recent ones. In their recent monumental publication concerning the deaths associated with almost 600,000 anesthesias and operations, Beecher and Todd[40] report that deaths occurred much less frequently when regional anesthesia was the primary method. They found that with regional techniques (exclusive of spinal anesthesia) the death rate was 1:6,100, whereas with ether it was 1:1,100, with cyclopropane 1:2,300, and with Pentothal-nitrous oxide 1:1,800. Moreover, the additional use of curare increased the mortality rate considerably, a finding which suggested to these authors that curare has an inherent toxicity; thus, with Pentothal-nitrous oxide-curare the mortality rate was 1:670, with cyclopropane-curare it was 1:240, and with ether-curare it was 1:62. In other words, when regional anesthesia was used the mortality rate was

only 1/6 that with ether and 1/100 that with ether-curare. These studies certainly indicate that the use of these drugs is not without hazard and that the widespread custom of using them for many trivial purposes is not justified.

In another very impressive long-term study of patients who received over 10,000 spinal anesthetics, Dripps and Vandam[41] found that the mortality rate following spinal anesthesia was much lower than that recorded after general anesthesia. This concurs with our experience[9] and that of Moore.[7] Our combined statistics reveal that among 61,400 patients who had received regional anesthesia there were 8 deaths which were considered to be due solely to the anesthetic, or a mortality rate of 1:7,675 while in a similar group of patients who received general anesthesia the deaths due solely to the anesthetic were 1:4,000. Moreover, in analyzing a series of 34 cases of cardiac arrest which occurred on the operating table in the course of eight years during which approximately 110,000 anesthetics were administered in six hospitals in the Tacoma area, it was found that 9 of the patients had received regional anesthesia while 25 had received general anesthesia. It is important to note that during this period 46.5% of the patients were anesthetized with regional techniques and 53.5% with general methods. Other authors who have reported on cardiac arrest also have indicated that this catastrophe occurs much less frequently with regional anesthesia.[33]

Other advantages of regional anesthesia may be briefly mentioned. It is particularly useful in urgent situations when little is known about the patient. If shock is caused by the pain, as is the case in patients with a crushed extremity or perforated viscus, regional anesthesia effects rapid improvement by relieving the pain. Of course, if shock is due to blood loss, adequate fluid replacement is necessary. It is also of great value whenever it is necessary to operate on a patient with a stomach full of undigested food. It should be remembered that pain, shock, nervousness, and other factors which are usually present in patients requiring emergency operation markedly decrease digestion and delay the emptying time of the stomach. In spite of preoperative gastric intubation, many of these patients contain undigested material hours after the injury so there is a real danger of vomiting and aspiration during induction with general anesthesia. Patients in shock tolerate regional anesthesia (extensive subarachnoid or peridural block excepted) better than general anesthesia.

In recent years the advantages of regional anesthesia in obstetrics have become fully appreciated; it not only offers the aforementioned benefits to the mother, but does not produce fetal depression. This is particularly important in premature births and with cesarean section. Representative statistics have been recently published by Taylor,[42] who reported that an abrupt change from general anesthesia to regional block for cesarean section was followed by a decrease in infant mortality from 19% to 8%.

The advantages of regional anesthesia in outpatients and in those individuals who dread losing consciousness have been recognized for years, especially by the dental profession. This method is also preferable when the Kraske, prone, lateral, and other unusual positions are to be employed as obtains in pilonidal cystectomy, hemorrhoidectomy, and excision of herniated lumbar disk. Since, if general anesthesia is used, it is essential to insert an endotracheal tube to assure the patient a patent airway, I believe it is simpler to use a regional procedure. Whenever fluoroscopy or x-ray is a necessary adjunct to the surgical procedure, regional anesthesia eliminates the danger of explosions, respiratory depression, or obstruction in the darkened room, and the patient is able to cooperate with the surgeon. The fact that regional anesthesia obviates the fire and explosive hazard under any circumstance is an important consideration which has been recently emphasized by Dr. Arnold Jackson.[43]

One of the most significant advantages of regional anesthesia to the patient is the minimal postanesthetic nausea and vomiting. In addition, the immediate postoperative period usually can be made pain free by employing one of the longer acting local anesthetic agents such as Pontocaine, or by using the continuous technique. All of these factors permit earlier ambulation and oral feeding. Consequently, the incidence of postoperative pulmonary, gastrointestinal, and thromboembolic complications is decreased.

ADVANTAGES TO THE SURGEON

The benefits derived by the surgeon are also numerous. With an adequate block he has optimum operation conditions with complete sensory blockade. By varying the strength of the anesthetic solution, motor power may or may not be abolished. A higher strength solution will cause muscular relaxation not obtained with general anesthetics unless large amounts of these agents are used or muscle relaxants are employed. If muscular relaxation is not necessary, the use of weaker solutions produces analgesia without interfering with motor function. This is of importance in tendon repair since the patient may aid the surgeon in identifying the structures. Regional anesthesia is advantageous to the surgeon in other instances in which the cooperation of the patient is needed as obtains in thyroidectomy, chordotomy, and excision of parts of the cerebrum in epilepsy.[44] In the absence of the anesthesiologist the surgeon who is experienced in regional techniques may block the patient and then perform the operation. Although this practice should be discouraged when it isn't necessary, it is of great advantage in rural practice where a specialist in anesthesiology is not always available. In addition regional anesthesia makes possible many minor operations in office practice.

ADVANTAGES TO THE ANESTHESIOLOGIST

It is advantageous for the anesthesiologist to use this type of anesthesia for with experience it can be executed readily and is effective in a high percentage of cases. Since this method in properly selected cases produces less physiologic alteration to the patient, there is naturally less tension placed on the anesthesiologist. Furthermore, it is economical to use and the equipment necessary is not bulky and can be transported easily. In unusual circumstances when the economical use of surgeons, anesthesiologists, and nurses is important, regional anesthesia is of great value. On many occasions during the war, circumstances forced some of us to run several operating rooms with only technicians assisting. In such instances regional anesthesia was the safest and best method. As previously mentioned, experience with regional anesthesia for surgery promotes proficiency and skill which can be used to great advantage in aiding the management of nonsurgical patients with this method.

ADVANTAGES TO THE WARD NURSES

Ward nurses appreciate the use of regional anesthesia. Patients who return to the wards awake without nausea or vomiting and are able to help themselves immediately and so relieve the nursing staff of a load which makes possible the surgical care of many more patients at one time. Moreover, better care of those patients who are considered in poor physiologic condition is permitted.

Disadvantages of Regional Anesthesia

I hope that in depicting such a favorable picture in order to support the cause of regional anesthesia, I have not given the impression that it is a panacea and its use is without drawbacks and limitations, for unfortunately such is not the case. There are many operations and circumstances in which general anesthesia is preferable. Moreover, it should be emphasized that a "fancy" block that is inadequate for the operation on hand does more harm than general anesthesia.

One of the most significant disadvantages and limitations of this method is that it is much more difficult to master its techniques than those of general anesthesia. It is a hard and long road which is strewn with many obstacles that can only be surmounted by being equipped with sound principles and observing important requisites. At best, all needling techniques are inherently inaccurate because they entail penetration of the unbroken skin without a visual guide. This, coupled with the existence of unpredictable anatomical variations, makes a precise injection difficult to master. It is much simpler to learn to introduce a needle into a vein which is under direct vision and inject the "magic mixtures" than to try to locate a nerve blindly at varying depths beyond the skin.

Failures are discouragingly frequent at the beginning and cause those not imbued with the enthusiasm that is necessary to master regional anesthesia to discard it in favor of other methods. Of course, the incidence of failure decreases with experience; but even the most skilled regional anesthesiologist has occasional discouraging results. Moreover, the onset is slower and duration of anesthesia is less predictable with re-

gional techniques than is the case with narcosis, although newer local anesthetic drugs have minimized these factors.

Another important disadvantage and limitation of analgesic block is that a certain amount of discomfort is inherent with the method. Although the degree of discomfort can be reduced by proper psychic preparation of the patient, preliminary medication, the use of sharp needles, and gentleness and dexterity during the execution of the block, it cannot be totally eliminated without narcotizing the patient.

Regional anesthesia, like many other forms of therapy, is not applicable to all circumstances and patients. Intracranial, intrathoracic, and extensive operations about the head and neck are best done with general anesthesia administered with an endotracheal tube. It is best to avoid blocks which produce extensive vasomotor paralysis in patients with severe disease of the cardiovascular system. It is also best to avoid use of the method in psychoneurotics and in patients who give a history of having had a serious complication following regional anesthesia. It has been frequently stated that this method cannot be used in children. However, we have successfully employed various regional anesthetic procedures, including brachial plexus block, sciatic nerve block, subarachnoid and segmental peridural block, in patients as young as one year of age. The secret of success is to use proper psychologic preparation, adequate premedication, and skill in technique.

Perhaps the most serious disadvantage of regional anesthesia is that complications, some of which may be serious, can and do occur. While it is true that their incidence decreases as the physician improves with dexterity and skill, a point of minimum incidence is eventually reached, below which it seems impossible to progress. Those clinicians who claim that they have no complications are either not doing regional blocks or do not follow their patients adequately. Fortunately, most complications are not serious if treated properly.

The most frequent complication is alteration in blood pressure as a result of either extensive sympathetic paralysis as obtains in high spinal, peridural, and splanchnic block, or reaction to the technique. It is important to recognize that various etiologic factors, including overdosage of the local anesthetic drug, the vasoconstricting agent, psychologic stress, and allergy, may produce such reactions. Hypersensitivity to local anesthetics is rare. Other complications that may occur include headache, hematomata, pneumothorax, total spinal anesthesia, and neuropathy. In viewing 1,400 diagnostic and therapeutic blocks, Adriani and Evangelou[45] found these complications occurred in 12 patients, an incidence of 0.85%. This is an unusually low incidence when one considers that 98% of the blocks were done by residents. Transient paresthesia and other sensory disturbances occur even less frequently, and prolonged or permanent neurologic sequelae are extremely rare. In one of the aforementioned studies, Dripps and Vandam[41] noted that with spinal anesthesia, which can be considered as the most notorious offender in this respect, this problem is not as serious as some authorities would lead us to believe.[46, 47] They found that none of the 8,460 patients who received 10,098 subarachnoid blocks developed transverse myelitis or adhesive arachnoiditis, the so-called cauda equina syndrome.

In my practice I have encountered this complication once in a series of over 14,000 spinals administered by personnel of my departments during a period of 12 years. This occurred in a patient with an unknown blood dyscrasia that caused bleeding following a subarachnoid block, with consequent pressure on the spinal cord elements. Admittedly, this is a serious complication; but when one considers that during this same period three times as many patients died while under general anesthesia as died with regional anesthesia in spite of the fact equal numbers were anesthetized with each method, the advantages of regional anesthesia become obvious. Moreover, it should be noted that many cases of serious neurologic complications following general anesthesia have been reported[48, 49] These have resulted mostly from brain damage secondary to cerebral anoxia, which, according to Courville,[48] who has written extensively on the subject, still constitutes a great threat to the patient under general anesthesia. It should also be added that deaths from cardiac arrest, explosions, medullary depression, and aspirations occur much more frequently with general anesthesia than paralysis occurs following spinal and other forms of regional anesthesia.

The paradoxical thing about comparing

complications of general anesthesia with those of regional blocks is that in the minds of the lay people and some physicians the paralysis is considered much more serious than the deaths that occur with general anesthesia.

Nerve Blocks for Intractable Pain

In patients whose physical condition contraindicates major neurosurgical operations, pain is best treated with analgesic blocks. Although this method has certain limitations, it has a great deal more to offer than prolonged narcotic therapy. Effective blocks produce adequate relief of pain and enable the sufferers to receive more intensive radiation therapy and other forms of medical treatment which otherwise could not be tolerated. Properly executed blocks do not significantly add to the patient's discomfort and are not accompanied by the depression and addiction of narcotic therapy. Nerve blocks do not tax the physiologic and psychologic resources of the patient to the same extent as do neurosurgical operations, nor do they impose the same risk.

Agents and Techniques

The claim that procaine is the safest and most satisfactory agent is not borne out in clinical practice. Xylocaine, Cyclaine, and Chlorprocaine have the advantage over the standard drug of producing anesthesia much more rapidly. When these drugs are injected in the proximity of nerve trunks, anesthesia is produced in five to eight minutes, whereas with extradural blocks these agents have a latent period of 10 to 15 minutes. In over 8,000 cases we have found dilute solutions (0.1–0.2%) Pontocaine much less toxic than procaine. Moreover, this drug produces anesthesia that is two to three times as long as that produced by the standard drugs.[50]

The following techniques deserve special mention: brachial plexus block for surgery of the upper extremity and sciatic-femoral block for surgery of the legs, cervico-thoracic and lumbar sympathetic block for diagnosis and/or therapy of various disorders, and block of the trigeminal nerve or its branches for conditions about the face. In recent years we have found segmental peridural block of great value for operative and obstetrical anesthesia and for management of various nonsurgical disorders in all parts of the body below the clavicle.[51]

Summary

An attempt has been made to depict the proper role of regional anesthesia in surgery, obstetrics, diagnosis, and therapy. In properly selected cases regional anesthesia offers advantages to the surgical patient and to the physician which are difficult to duplicate with general anesthesia. Regional anesthesia produces less physiologic disturbance during the operation and fewer postoperative complications. It is particularly useful in emergencies and operations of the extremities, lower abdomen, back, and superficial parts of the body. In obstetrics this method may be preferred because of the benefits derived by the mother and infant. It offers the surgeon and obstetrician optimal operation conditions.

Interruption of pain pathways may be applied to the management of many nonsurgical disorders which are manifested primarily by pain. The pain and dysfunction associated with neuralgia, causalgia, and other reflex dystrophies; peripheral vascular disorders; musculoskeletal problems; visceral diseases; and cancer may be effectively relieved with this method.

In order to obtain good results it is essential to have thorough knowledge of neuroanatomy; of the various block techniques; of the pharmacological properties of local anesthetic drugs; and of the possible complications, their prophylaxis, and treatment. Proper psychologic and pharmacologic preparation of the patient is important.

Tacoma General Hospital.

REFERENCES

1. Hunt, J.: Personal communication to the author.
2. Faulconer, A., and Lundy, J. S.: Selection of anesthetic, in Hale, D. E.: Anesthesiology, Philadelphia, F. A. Davis Company, 1954, pp. 162–200.
3. Alexander, F. A. D.: Personal communication to the author.
4. Gillies, J.: Personal communication to the author.
5. MacIntosh, R. R., and Bryce-Smith, R.: Local Analgesia: Abdominal Surgery, Edinburgh and London, E. & S. Livingstone Ltd., 1953.
6. Moore, D. C.: Regional Block, Springfield, Ill., Charles C Thomas, 1953.
7. Moore, D. C.: Personal communication to the author.
8. Pitkin, G.: Conduction Anesthesia, Philadelphia, London, and Montreal, J. B. Lippincott Company, 1946.
9. Bonica, J. J.: Role of anesthesiologist in management of cardiac arrest, Anesth. & Analg. 31:1–18 (Jan.–Feb.) 1952.
10. Brewster, W. R., Jr., Isaacs, J. P., and Wainø-Andersen, T.: Depressant effect of ether on myocardium of dog and its modification by reflex release of epinephrine and nor-epinephrine, Am. J. Physiol. 175:399–414 (Dec.) 1953.

11. Fisher, C. W., Bennett, L. L., and Allahwala, A.: Effect of inhalation anesthetic agents on myocardium of dog, Anesthesiology 12:19–26 (Jan.) 1951.
12. Zweifach, B. W., and Hershey, S. G.: Predisposing action of anesthetic agents on vascular responses in hemorrhagic shock, Surg., Gynec. & Obst. 89:469–477 (Oct.) 1949.
13. Gordh, T.: Postural circulatory and respiratory changes during ether and intravenous anesthesia; experimental analysis of significance of postural changes during anesthesia with special regard to value of head-down posture in resuscitation, Acta chir. Scandinav. (supp. 102) 92:1–126, 1945.
14. Johnson, S. R.: Effect of some anaesthetic agents on circulation in man, Acta chir. Scandinav. (supp. 158) 1–143, 1951.
15. Reynolds, C.: Dangers of prolonged Pentothal Sodium anesthesia from pharmacological standpoint, Anesth. & Analg. 18:270–273 (Sept.–Oct.) 1939.
16. Stephen, C. R., and Pasquet, A.: Anesthesia for neurosurgical procedures; analysis of 1,000 cases, Anesth. & Analg. 28:77–88 (March–April) 1949.
17. Lockett, J.: Hypotension following soluble Thiopentone, and its prevention by use of Methedrine, Anaesthesia 6:83–87 (April) 1951.
18. Stephen, C. R., Nowill, W. K., and Martin, R.: Diagnosis and treatment of hypotension during anesthesia, Anesthesiology 14:180–194 (March) 1953.
19. King, B. D., Harris, L. C., Jr., Greifenstein, F. E., Elder, J. D., Jr., and Dripps, R. D.: Reflex circulatory responses to direct laryngoscopy and tracheal intubation performed during general anesthesia, Anesthesiology 12:556–566 (Sept.) 1951.
20. Hershey, S. G., and Rovenstine, E. A.: Value of cyclopropane in anesthetic management of patients with recent severe hemorrhage, Anesthesiology 5:149–158 (March) 1944.
21. Hershey, S. G., and Zweifach, B. W.: Peripheral vascular homeostasis in relation to anesthetic agents, Anesthesiology 11:145–154 (March) 1950.
22. Hershey, S. G., Zweifach, B. W., and Rovenstine, E. A.: Effects of depth of anesthesia on behavior of peripheral vascular bed, Anesthesiology 14: 245–254 (May) 1953.
23. Zweifach, B. W., Chambers, R., Lee, R. E., and Hyman, C.: Reactions of peripheral blood vessels in experimental hemorrhage, Ann. New York Acad. Sc. 49:553–570 (May 11) 1948.
24. Zweifach, B. W., Hershey, S. G., Rovenstine, E. A., Lee, R. E., and Chambers, R.: Anesthetic agents as factors in circulatory reactions induced by hemorrhage, Surgery 18:48–65 (July) 1945.
25. Guedel, A. E.: Inhalation Anesthesia, New York, The Macmillan Company, 1937.
26. Bonica, J. J.: Disturbi cardiovascolari durante anestesia e chirurgia, Minerva Anestesiologica, Anno XX, N. 10 (Oct.) 1954.
27. Burstein, C. L.: Fundamental Considerations in Anesthesia, New York, The Macmillan Company, 1949.
28. Burstein, C. L., LoPinto, F. J., and Newman, W.: Electrocardiographic studies during endotracheal intubation; effects during usual routine technics, Anesthesiology 11:224–237 (March) 1950.
29. Burstein, C. L., Martin, S. J., and Rovenstine, E. A.: Threshold variations to vagus nurse stimulation, J. Thoracic Surg. 13:49–52 (Feb.) 1944.
30. Burstein, C. L., Piazza, T. L., Kapp, L. A., and Rovenstine, E. A.: Cardiocirculatory disturbances during intrathoracic surgery, Surgery 25:36–46 (Jan.) 1949.
31. Burstein, C. L., Woloshin, G., and Newman, W.: Electrocardiographic studies during endotracheal intubation. Effects during general anesthesia and intravenous procaine, Anesthesiology 11:299–312 (May) 1950.
32. Reid, L. C., and Brace, D. E.: Irritation of respiratory tract and its reflex effect upon heart, Surg., Gynec. & Obst. 70:157–162 (Feb.) 1940.
33. Stephenson, H. E., Jr., Reid, L. C., and Hinton, J. W.: Some common denominators in 1200 cases of cardiac arrest, Ann. Surg. 137:731–744 (May) 1953.
34. Jacoby, J. J.: Personal communication to the author.
35. Goodman, L. S., and Gilman, A.: Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955.
36. Toman, J. E. P., and Davis, J. P.: Effects of drugs upon electrical activity of brain, Pharmacol. Rev. 1:425–492 (Dec.) 1949.
37. Crile, G. W., and Lower, W. E.: Anoci-association, Philadelphia and London, W. B. Saunders Company, 1914.
38. Beecher, H. K., Bennett, H. S., and Bassett, D. L.: Circulatory effects of increased pressure in airway, Anesthesiology 4:612–618 (Nov.) 1943.
39. Cournand, A., Motley, H. L., Werko, L., and Richards, D. W., Jr.: Physiological studies of effects of intermittent positive pressure breathing on cardiac output in man, Am. J. Physiol. 152:162–174 (Jan.) 1948.
40. Beecher, H. K., and Todd, D. P.: Study of Deaths Associated with Anesthesia and Surgery, Springfield, Ill., Charles C Thomas, 1954.
41. Dripps, R. D., and Vandam, L. D.: Long-term follow-up of patients who received 10,098 spinal anesthetics, J.A.M.A. 156:1486–1491 (Dec. 18) 1954.
42. Taylor, E. S.: Role of analgesia and anesthesia in fetal salvage, J.A.M.A. 156:1481–1483 (Dec. 18) 1954.
43. Jackson, A. S.: Anesthetic explosion (editorial), J. Internat. Coll. Surgeons 23:398–401 (March) 1955.
44. Penfield, W.: Combined regional and general anesthesia for craniotomy and cortical exploration, Anesth. & Analg. 33:3, 156 (May) 1954.
45. Adriani, J., and Evangelou, M.: Complications of regional anesthesia, Anesth. & Analg. 34:96–101 (March–April) 1955.
46. Kennedy, F., Effron, A. S., and Perry, G.: Grave spinal cord paralyses caused by spinal anesthesia, Surg., Gynec. & Obst. 91:385–398 (Oct.) 1950.
47. Thorsen, G.: Neurological complications after spinal anesthesia and results from 2493 follow-up cases, Acta chir. Scandinav. (supp. 121) 95: 1–272, 1947.
48. Courville, C. B.: Untoward Effects of Nitrous Oxide Anesthesia, Mountain View, California, Pacific Press Publishing Association, 1939.
49. Moore, D. C.: Complications of Regional Block, Springfield, Ill., Charles C Thomas, in press.
50. Bonica, J. J.: Management of Pain, Philadelphia, Lea & Febiger, 1953.
51. Bonica, J. J.: Clinical evaluation of segmental peridural block, J. Michigan M. Soc. 53:167–178; 191 (Feb.) 1954.
52. Bennett, H. S., Bassett, D. L., and Beecher, H. K.: Influence of anesthesia (ether, cyclopropane, sodium Evipal) on circulation under normal and shock conditions, J. Clin. Investigation 23: 181–208 (March) 1944.
53. Bonica, J. J.: Anesthesia and surgery in cardiac patients, in Massey, F.: Clinical Cardiology, Baltimore, Williams & Wilkins Company, 1952.
54. Bonica, J. J.: Cardiac arrest, Northwest Med. 52: 719–723 (Sept.) 1953.

Comments on Treatment

Editor—HARRY BECKMAN, M. D., Marquette University, Milwaukee

What Newly Introduced Drug Has the Ability to Combat the Respiratory Depression Without Lessening the Analgesic Properties of Morphine?

The answer is Diamino-phenylthiazole, which has been abbreviated as DAPT by Shaw and Shulman, who introduced the drug into the clinic at the University of Melbourne, Australia, after preliminary studies on the laboratory level. Apparently this drug has little effect on the analgesic properties of morphine but reveals a striking and lasting antagonism to its respiratory depressant effects, thus making it possible to use quite large doses of morphine safely in individuals with excruciating and intractable pain. In addition to the apparent safety with which the drug can be used, there seem also to be no pharmacologic contraindications to the employment at the same time of such drugs as scopolamine, atropine, the barbiturates, and chlorpromazine. Preliminary studies have also shown that DAPT delays, at least, and perhaps even prevents the onset of tolerance to morphine.

The method of using the drug consists of gradually increasing the dosage of morphine in 16 mg. (¼ gr.) increments with DAPT in 15 mg. dosage over one or two days until the desired degree of analgesia is obtained. Dosages required for complete relief in the 35 patients with terminal malignancies in the series of Shaw and Shulman[1] are shown in the table. In 31 of these patients dosage remained unaltered until death; in 4 the dose was increased to 2 gr. during the final two days. About a fourth of the patients were depressed at the beginning of treatment but had a favorable change in outlook after the first week. The following is an abbreviated case report.

MORPHINE DOSAGES

Morphine Dose to Give 8 Hr. Analgesia	Patients Receiving Relief
¼ gr. (16 mg.)	2
¾ gr. (48 mg.)	3
1 gr. (65 mg.)	8
1⅓ gr. (88 mg.)	10
1⅔ gr. (110 mg.)	6
2 gr. (130 mg.)	5
2½ gr. (160 mg.)	1
Total	35

A woman, aged 38, with cancer of the breast, striking edema of the left arm, and intolerable pain, received no more than two hours' relief from 16 mg. (¼ gr.) morphine. The combined morphine-DAPT treatment was begun, and she was stabilized on 1¾ gr. morphine and ¼ gr. DAPT intramuscularly three times daily. She was without pain and had decrease in vomiting, and constipation was rectified. On the fourth day, 20 mg. DAPT orally was substituted for intramuscular injection. Later, 40 mg. DAPT was given at each treatment during the day to combat slight sedation, the nightly dose remaining at 20 mg. Two months later, the dose of morphine was increased to 2 gr. three times a day; this may have been due to development of tolerance or to increased pain. There were no untoward side reactions. The patient died after 18 weeks' treatment.

Further report on the clinical use of this new drug in a large series of patients will be eagerly awaited.—HARRY BECKMAN, M.D.

REFERENCE

1. Shaw, F. H., and Shulman, A.: Treatment of intractable pain with large doses of morphine and Diamino-phenylthiazole, Brit. M. J. 1:1367–1369 (June 4) 1955.

JOHN HARRIS MEMORIAL LECTURE FUND

A memorial fund has been established in memory of John Harris, M. D., late professor and head of the department of obstetrics and gynecology at the University of Wisconsin. The fund will be used to provide for an annual lecture at the University in the field of obstetrics and gynecology by some nationally known specialist in the field.

Contributions to the fund should be directed to John Z. Bowers, M. D., Dean, University of Wisconsin Medical School.

1956 Annual Meeting Program

The 1956 Annual Meeting Scientific programs were prepared under the immediate direction of M. G. Rice, M. D., Stevens Point, in cooperation with the Council on Scientific Work of the State Medical Society and representatives of the several sections of the Society and specialty organizations in Wisconsin.

Council on Scientific Work

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Marshfield
Medical Editor, Wisconsin Medical Journal

★ **REGISTRATION:** Secure your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Kilbourn Street. Registration hours: Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, hospital personnel and medical assistants, admitted on Thursday, if previously certified, or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND MD'S IN MILITARY SERVICE:** Members of Veterans Administration must be members of the Society to be admitted. Those physicians in armed services admitted by presenting certification of current military service.

★ **TELEPHONE SERVICE:** At Milwaukee Auditorium —During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to BR 3–7250 or BR 3–7251. Calls for Milwaukee doctors should be directed through Physicians Service Bureau (Broadway 1–4131), and they will be transmitted to a staff member of the Medical Society of Milwaukee County in attendance at the Auditorium to receive the calls. At the Hotel Schroeder—Delegates can be reached during sessions of the House by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Broadway 1–7250). Those attending luncheons at the Schroeder Hotel can be reached in the same manner between 12:00–2:00 p.m. If you are attending luncheons, inform your secretary of your schedule, so you can be located promptly if you are to be called. Give your secretary the number or letter of the room where the luncheon will be held.

★ **RESERVATIONS FOR REFRESHER COURSES:** Refresher courses on Tuesday, Wednesday and Thursday, 9:00 to 10:00 a.m., are limited to 40 physicians each. Admittance by ticket only. Reservations accepted until maximum is reached. All reservations will be confirmed. Pick up refresher course tickets at registration desk. *Those not picked up by 8:45 a.m. each morning will be released on first come-first served basis.*

★ **RESERVATIONS FOR ANNUAL DINNER:** Reservations for annual dinner (7:00 p.m., Thursday, May 3) may be obtained at registration desk in Milwaukee Auditorium from 8:00 a.m. to 4:00 p.m. each day. Attendance at annual dinner by ticket only. Limit 450.

★ **RESERVATIONS FOR GOLF TOURNAMENT:** Contact Mr. A. H. Luthmers, Medical Society of Milwaukee County, Bankers Building, Milwaukee. $10.00 covers all costs including green fees. Tournament will be held at the Brynwood Country Club, 6000 West on Good Hope Road, Milwaukee, on Monday, April 30. Tee-off time, 11:00 a.m. Dinner and presentation of awards, 6:30 p.m.

YOU NEED THESE RESERVATIONS

Refresher Courses

Write to State Medical Society office indicating first, second and third choice for each course you wish to attend.

Specialty Luncheons and Dinners

See noon and evening listings in the program.

Annual Dinner, 7 p.m., Thursday, May 3

Write to State Medical Society office. Enclose $6.00 per ticket for reservation.

New Member Luncheon, 12 Noon, Wednesday, May 2

All physicians who became new members of the Society since May, 1955, are invited. Special invitation will be sent by Society.

Golf Tournament, Monday, April 30

See above.

Timetable Summary

TUESDAY, MAY 1—GENERAL PRACTICE DAY

8:00 a.m. Registration and Exhibits Open

9:00 a.m. Refresher Courses

10:45 a.m. General Program

12:00 Noon Wisconsin Dermatological Society Luncheon

2:00 p.m. General Program

5:15 p.m. Delegates' Buffet Dinner (delegates only)

6:00 p.m. American Academy of Pediatrics Dinner (members only)

6:30 p.m. House of Delegates, First Session

8:30 p.m. Gemütlichkeit Night

WEDNESDAY, MAY 2

8:00 a.m. Registration and Exhibits Open

9:00 a.m. Reference Committees, House of Delegates

9:00 a.m. Refresher Courses

10:30 a.m. General Program

12:00 Noon New Member Luncheon
Clinic Managers Luncheon
Wisconsin Society of Pathologists Luncheon (open to all interested physicians)

12:30 p.m. Wisconsin Surgical Society Luncheon (members only)

2:00 p.m. Special Program on Surgery
Special Program on Obstetrics and Gynecology
Special Program on Radiology

6:00 p.m. Wisconsin Surgical Society Dinner (members only)
Wisconsin Society of Obstetrics and Gynecology Dinner (members only)
Wisconsin Radiological Society Dinner (members only)

7:30 p.m. House of Delegates, Second Session

THURSDAY, MAY 3

8:00 a.m. Registration and Exhibits Open

8:30 a.m. House of Delegates

9:00 a.m. Refresher Courses
Special Program on Internal Medicine

10:30 a.m. General Program

12:00 Noon Past Presidents' Luncheon
Section on Ophthalmology & Otolaryngology Luncheon (members only)
Wisconsin Urological Society Luncheon (members only)

12:30 p.m. Wisconsin Society of Internal Medicine Luncheon (members only)

1:40 p.m. Special Program on Internal Medicine

2:00 p.m. Special Program of Section on Medical History (open to all interested physicians)
Special Program on Anesthesia
Special Program on Urology

2:15 p.m. Special Program of the Section on Ophthalmology and Otolaryngology

5:30 p.m. President's Reception

6:00 p.m. Wisconsin Society of Anesthesiologists Dinner (members only)
Wisconsin Urological Society Dinner (members only)

7:00 p.m. Annual Dinner

PROGRAM

TUESDAY, MAY 1
GENERAL PRACTICE DAY

Program sponsored by the Wisconsin Academy of General Practice. Meetings open to all physicians. Approval has been given to permit Academy members to qualify for maximum hours of credit in Category I.

8:00 a.m.—Registration Opens, Milwaukee Auditorium

Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—REFRESHER COURSES

(1) "The Maintenance of Health of the Geriatric Patient"

WILLIAM B. KOUNTZ, M.D., *Assistant Clinical Professor of Medicine, Washington University,* St. Louis, Missouri

Juneau Hall (40 physicians—by ticket only)

(2) "Drugs and Malignancy"

HARRY BECKMAN, M.D., Milwaukee

Room 3, Sports Arena (40 physicians — by ticket only)

(3) "The Uses and Abuses of Steroids in Dermatology"

ROBERT KIERLAND, M.D., *Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota,* Rochester, Minnesota

DONALD M. RUCH, M.D., Milwaukee, Moderator

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "Recent Developments in the Diagnosis and Treatment of Poliomyelitis"

RANDOLPH BATSON, M.D., *Associate Professor of Pediatrics, Vanderbilt University,* Nashville, Tennessee

PETER WISNIEWSKI, M.D., Milwaukee

J. C. PETERSON, M.D., Milwaukee, Moderator

Kilbourn Hall—A Panel (40 physicians—by ticket only)

(5) "Lesions of the Anus, Rectum and Colon"

FREDERICK A. COLLER, M.D., *Professor of Surgery, University of Michigan Medical School,* Ann Arbor, Michigan

CARL EBERBACH, M.D., Milwaukee, Moderator

Room 2, Sports Arena (40 physicians — by ticket only)

10:00 a.m.—Recess to View Exhibits

★

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

RAY RICHARDS, M.D., Eau Claire, *President, Wisconsin Academy of General Practice,* Moderator

10:45 a.m.—"Drugs in Relation to Geriatrics of Special Interest to General Practitioners"

WILLIAM B. KOUNTZ, M.D., *Assistant Clinical Professor of Medicine, Washington University,* St. Louis, Missouri

Graduate of Washington University. Director of scientific research for the Gerontological Research Foundation and president of the Gerontological Society. He will discuss the indications for the use of various drugs in gerontology. "The direct use of drugs should be avoided unless there is thorough knowledge of the physiological need and response of the patient."

11:15 a.m.—"Papanicolaou Smears: An Opportunity for Diagnosis for General Practitioners"

WILLIAM D. STOVALL, M.D., Madison

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Tuesday Noon

12:00 noon—Wisconsin Dermatological Society Luncheon (members only)

Milwaukee Athletic Club

Reservations through Donald Ruch, M.D., 208 E. Wisconsin, Milwaukee

Paper presented by Robert R. Kierland, M.D.

Tuesday Afternoon

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

ROBERT F. PURTELL, M.D., Milwaukee, *President-Elect, Wisconsin Academy of General Practice,* Moderator

2:00 p.m.—"What's New and What's True in What's New in Dermatology"

HERBERT RATTNER, M.D., *Professor and Chairman, Department of Dermatology and Syphilology, Northwestern University School of Medicine,* Chicago, Illinois

Native of Chicago, now chief editor of the A.M.A. Archives of Dermatology. He will consider new concepts with respect to the cause of itching; status of steroid therapy; advances in mycology; the use of antimalarial drugs for skin diseases; and the treatment of acne scars by dermabrasion.

2:30 p.m.—"Acute Hepatitis in Infancy and Childhood"

RANDOLPH BATSON, M.D., *Associate Professor of Pediatrics, Vanderbilt University,* Nashville, Tennessee

Native of Mississippi. Graduate of Vanderbilt University School of Medicine. Currently director of Vanderbilt Poliomyelitis Respiratory Center. Interested in polio principally from the standpoint of respiratory physiology and management.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Surgery of the Gallbladder and the Bile Ducts"

FREDERICK COLLER, M.D., *Professor of Surgery, University of Michigan Medical School,* Ann Arbor, Michigan

A native of South Dakota and a graduate of the Harvard Medical School in 1912. Internship and residency at Massachusetts General Hospital. Following service in World War I, he came to the University of Michigan. He is a past-president and regent of the American College of Surgeons and a past-president of the American Surgical Association.

[New Delegates' Meeting at 4:00 p.m., Parlor A, Schroeder Hotel]

4:15 p.m.—"Visible Tumor Clinic" (Kodachromes)

STURE A. M. JOHNSON, M.D., Madison, Moderator

ROBERT KIERLAND, M.D., *Associate Professor of Dermatology and Syphilology, Mayo Foundation Graduate School, University of Minnesota,* Rochester, Minnesota

Note: This unusual presentation of visible tumors, both benign and malignant, will be made with Kodachromes. History and photomicrographs of biopsies will be presented along with a panel discussion on differential diagnosis and treatment. Emphasis will be placed on clinical appearance and its implications in establishing the diagnostic procedures that might be employed.

HARRY R. FOERSTER, M.D., Milwaukee

DAVID KERSTING, M.D., Milwaukee

Doctor Kierland

Graduate of University of Minnesota Medical School. Special consultant, U.S.P.H.S.; member of Editorial Board of Journal for Investigative Dermatology. Will discuss the benign lesions which may be confused with malignant and pre-malignant lesions. Emphasizes the cutaneous signs by which underlying malignant disease may be recognized.

Note: The appearances of Doctors Rattner and Kierland have been made possible through the cooperation of the Wisconsin Dermatological Society.

Opening Day Is General Practice Day

Tuesday Evening

5:15 p.m.—Delegates' Buffet Dinner (delegates only)

Pere Marquette Room, Schroeder Hotel

6:00 p.m.—American Academy of Pediatrics Dinner (members only)

Reservations through Karl Beck, M.D., 1411 Wauwatosa, Wauwatosa

Paper presented by Randolph Batson, M.D.

6:30 p.m.—House of Delegates, First Session

East Room, Schroeder Hotel

At this session, the reports of all officers and committees are presented. President-Elect, L. O. Simenstad, M.D., Osceola, will address the House and announce committee appointments for the ensuing year. A nominating committee is selected and new committee reports and new business considered and referred to the appropriate reference committees.

8:30 p.m.—Gemütlichkeit Night

Ballroom, Schroeder Hotel

All Society members and their wives are invited to an informal evening of entertainment. Talent, both professional and intraprofessional, will be featured. Come. Stay as long as you like.

HOTEL ACCOMMODATIONS FOR ANNUAL MEETING IN MILWAUKEE

Name of Hotel	*Single*	*Double*	*Twin Beds*
Medford	$4.50 to $ 5.25	$6.25 to $ 7.00	$ 8.50 to $10.00
Pfister	$5.00 to $ 9.00	$7.50 to $10.00	$ 8.00 to $12.00
Plankinton House	$5.50 to $10.00	$8.00 to $11.00	$ 9.00 to $15.00
*Schroeder	$5.00 to $ 8.00	$8.00 to $12.00	$10.00 to $16.00
Wisconsin	$4.50 to $ 8.00	$6.75 to $10.00	$10.00 to $11.50

* Headquarters hotel for Annual Meeting.

All rates listed above are for rooms with bath. Rates subject to change. Information about suites and large capacity rooms available on request.

HOTEL RESERVATION

State Medical Society of Wisconsin Annual Meeting—Milwaukee, May 1–2–3, 1956

Mail Direct to Hotel of First Choice

Hotel—First Choice: _____; Second: _____; Third: _____

Please reserve the following type room for me starting _____
Day Date

Single _____ Double _____ Twin Beds _____ (all with bath)

Please confirm this reservation to:

PRINT NAME: _____

ADDRESS: _____
Street City

WEDNESDAY, MAY 2

8:00 a.m.—Registration Opens, Milwaukee Auditorium
Scientific Exhibits Open, Milwaukee Auditorium

9:00 a.m.—Reference Committees of House of Delegates

9:00 a.m.—REFRESHER COURSES

(1) "Prolonged Labor"

WILLIAM MENGERT, M.D., *Professor of Obstetrics and Gynecology, University of Illinois College of Medicine,* Chicago, Illinois

CARLTON WIRTHWEIN, M.D., Milwaukee, Moderator

Kilbourn Hall (40 physicians—by ticket only)

(2) "Management of Benign and Malignant Lesions of the Breast"

GRANTLEY W. TAYLOR, M.D., *Assistant Clinical Professor of Surgery, Harvard Medical School,* Boston, Massachusetts

JAMES CONLEY, M.D., Milwaukee, Moderator
Juneau Hall (40 physicians—by ticket only)

(3) "Office Ophthalmology"

PETER DUEHR, M.D., Madison

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "Emergency Treatment of Hand Injuries"

FRANK D. BERNARD, D.D.S., M.D., Madison

Room 2, Sports Arena (40 physicians — by ticket only)

(5) "How to Handle the Newer Antibiotics in Pulmonary Lesions"

ELWOOD W. MASON, M.D., Milwaukee

Room 3, Sports Arena (40 physicians — by ticket only)

(6) "Contrast Examination of the Cardiovascular System"

M. M. FIGLEY, M.D., *Assistant Professor, Department of Radiology, University of Michigan Hospital,* Ann Arbor, Michigan

Room 4, Sports Arena (40 physicians — by ticket only)

10:00 a.m.—Recess to View Exhibits

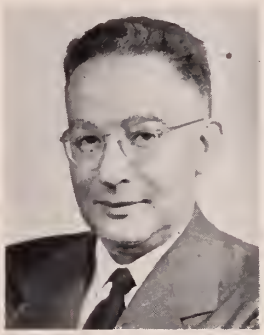
GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

MAURICE G. RICE, M.D., *General Program Chairman, Council on Scientific Work,* Moderator

10:30 a.m.—"Aids in the Diagnosis of Liver Disease"

EDWARD A. GALL, M.D., *Professor of Pathology, University of Cincinnati, College of Medicine,* Cincinnati, Ohio



Native of New York City. Graduate of Tulane University Medical School. Secretary of the American Association of Pathologists and Bacteriologists and currently director of laboratories, Cincinnati General Hospital. He has made significant contributions and investigations with regard to malignant lymphoma, pathogenesis of carcinoma, hepatitic disorders, and effects of radiation.

11:00 a.m.—"Gynecological Office Procedures"

JOHN E. FABER, M.D., *Sections of Obstetrics and Gynecology, Mayo Clinic,* Rochester, Minnesota

11:30 a.m.—"Malignant Melanoma"

GRANTLEY W. TAYLOR, M.D., *Assistant Clinical Professor of Surgery, Harvard Medical School,* Boston, Massachusetts

This lecture is sponsored by the Milwaukee and Wisconsin Divisions of the American Cancer Society. Native of New Jersey. Graduate of Harvard University Medical School. This paper is an end result study of 360 cases of malignant melanoma. Analysis will clarify the indications for regional dissections, the incidence of node metastases for various primary sites, and the adequacy and efficacy of standard regional dissections when nodes are involved. It appraises possible benefits from ultra radical and en bloc surgical procedures.

Be Sure To Pick Up Annual Dinner Tickets

Wednesday Noon

12:00 noon—New Member Luncheon
East Room, Schroeder Hotel

12:00 noon—Clinic Managers Luncheon
Parlor A, Schroeder Hotel

12:00 noon—Wisconsin Society of Pathologists Luncheon
Club Rooms, Schroeder Hotel

Open to all interested physicians.

"Some Pathological Features of Obstructive and Viral Hepatitis," Edward A. Gall, M.D., Cincinnati.

Reservations through Robert S. Haukohl, M.D., 1821 W. Wisconsin, Milwaukee

12:30 p.m.—Wisconsin Surgical Society Luncheon (members only)
Pere Marquette Room, Schroeder Hotel

Reservations through J. M. Sullivan, M.D., 161 W. Wisconsin, Milwaukee

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Wednesday Afternoon

SPECIAL PROGRAM ON SURGERY

JUNEAU HALL, MILWAUKEE AUDITORIUM

Planned in cooperation with the Wisconsin Surgical Society but open to all members of the State Medical Society.

S. B. Gundersen, M.D., La Crosse, *President, Wisconsin Surgical Society,* Moderator

2:00 p.m.—Presidential Address
"Cocktails, Canapes and Colic"
Thomas J. Snodgrass, M.D., Janesville

2:30 p.m.—"Diagnosis and Treatment of Occlusive Femoral Artery Disease"
James E. Conley, M.D., Milwaukee

2:40 p.m.—"Experiences with Pancreatic Tumors"
Sigurd B. Gundersen, Jr., M.D., La Crosse

3:00 p.m.—Recess to View Exhibits

3:15 p.m.—"Pulmonary Resection for Metastatic Lesions of the Lungs"
Joseph W. Gale, M.D., Madison

3:35 p.m.—"Problems in the Surgical Management of Duodenal Ulcer"
C. Sherrill Rife, M.D., Milwaukee

4:00 p.m.—Business Meeting (members only)

SPECIAL PROGRAM ON OBSTETRICS AND GYNECOLOGY

KILBOURN HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Society of Obstetrics and Gynecology but open to all members of the State Medical Society.

Dean D. Willson, M.D., Fond du Lac, *President, Wisconsin Society of Obstetrics and Gynecology,* Moderator

2:00 p.m.—A Panel:

"Hypofibrinogenemia"
George Hank, M.D., Madison

"Induced Labor in Modern Obstetrics"
L. H. Verch, M.D., Milwaukee

"Uterine Rupture"
Leo Grinney, M.D., Racine

"Transfusions in Modern Obstetrics"
T. J. Rice, M.D., Marshfield

Doctor Mengert and Doctor Faber will discuss the above presentations.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Highlights of Female Genital Cancer"

William Mengert, M.D., *Professor of Obstetrics and Gynecology, University of Illinois College of Medicine,* Chicago, Illinois

Native of Washington, D. C., and graduate of Johns Hopkins Medical School. He was professor and chairman of the Department of Obstetrics and Gynecology at the Southwestern Medical School of the University of Texas from 1943 until 1945. He has held various offices including that of general program chairman of the American Congress on Obstetrics and Gynecology and was chairman of the Test Committee in Obstetrics and Gynecology of the National Board of Medical Examiners from 1953 until 1955.

New Members: Come To Special Program Wednesday

SPECIAL PROGRAM ON RADIOLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Radiological Society but open to all members of the State Medical Society.

R. W. Byrne, M.D., Milwaukee, Moderator

2:00 p.m.—"Radiologic Evaluation of Mitral Valve Disease"

M. M. Figley, M.D., *Assistant Professor, Department of Radiology, University of Michigan Hospital,* Ann Arbor, Michigan

A native of Ohio and a graduate of the Harvard Medical School in 1944. Internship and residency at University Hospitals of Cleveland. After 23 months with the U. S. Army, he received an appointment at the University of Michigan. In 1953, he was awarded the 5-year Markle Scholarship in Medical Science.

2:30 p.m.—"Pathologically Proven Mediastinal Masses"

J. G. Bulgrin, *Captain, MC, USN,* Great Lakes, Illinois

A native of Illinois and a graduate of the University of Wisconsin in 1935. He entered the Medical Corps, U. S. Navy, in 1937 and has been on active duty continuously since that date. The chief interest in his presentation is the roentgen-pathologic correlation of common diseases in the young adult age group and demonstration of some vagaries of common diseases, as well as highly unusual lesions.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Tumors of the Chest in Infants and Children"

Hans Hefke, M.D., Milwaukee

4:05 p.m.—"Pyelovenous Backflow in Excretory Urology"

Gene Sengpiel, M.D., Milwaukee

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Wednesday Evening

6:00 p.m.—Wisconsin Surgical Society Dinner (members only)

University Club

Reservations through J. M. Sullivan, M.D., 161 W. Wisconsin, Milwaukee

"Keeping Abreast with the Breast Controversy," Grantley Taylor, M.D.

6:00 p.m.—Wisconsin Society of Obstetrics and Gynecology Dinner (members only)

Milwaukee Athletic Club

Reservations through W. V. Luetke, M.D., 1023 Regent, Madison

Paper presented by John Faber, M.D.

6:00 p.m.—Wisconsin Radiological Society Dinner (members only)

University Club

Reservations through R. W. Byrne, M.D., 3321 N. Maryland, Milwaukee

Paper presented by M. M. Figley, M.D.

7:30 p.m.—House of Delegates

East Room, Schroeder Hotel

This is the second session of the House of Delegates. Reference committees will begin reporting their recommendations on the reports of officers, standing committees, resolutions and amendments to the Constitution and By-Laws. New business may again be introduced.

All members of the Society are invited to attend.

An Invitation

One of the important functions of the Annual Meeting of the State Medical Society of Wisconsin is the conduct of the House of Delegates. At the first session of the House on Tuesday evening the reports of the officers and committees will be presented along with new business. On Wednesday morning at 8:30 the reference committees will meet at the Schroeder Hotel. Room assignments will be announced. It is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them. Any member, whether he wishes to appear before the committees or merely to listen in on their deliberations, is urged to participate in this very important aspect of Society affairs.

THURSDAY, MAY 3

8:00 a.m.—Registration Opens, Milwaukee Auditorium

Scientific Exhibits Open, Milwaukee Auditorium

8:30 a.m.—House of Delegates

East Room, Schroeder Hotel

9:00 a.m.—REFRESHER COURSES

(1) "Emergency Treatment of Head Injuries"—A Panel:

HARRY MAXWELL, M.D., Milwaukee, Moderator

HENRY SUCKLE, M.D., Madison

RAY QUADE, M.D., Neenah

Room 4, Sports Arena (40 physicians — by ticket only)

(2) "Recognition and Treatment of Toxic Psychoses"

VERNON KINROSS-WRIGHT, M.D., *Anderson Department of Psychiatry, Baylor University College of Medicine,* Houston, Texas

JAMES CAFFREY, M.D., Milwaukee, Moderator

Room 2, Sports Arena (40 physicians — by ticket only)

(3) "Hematuria"

MILTON COPLAN, M.D., *Clinical Professor, Division of Urology, Department of Surgery, University of Miami School of Medicine,* Miami, Florida

N. W. BOURNE, M.D., Milwaukee, Moderator

Room 1, Sports Arena (40 physicians — by ticket only)

(4) "The Use of Depressant Drugs"

STUART CULLEN, M.D., *Professor of Surgery and Chairman of Division on Anesthesiology, State University of Iowa, University Hospitals,* Iowa City, Iowa

MILTON DAVIS, JR., M.D., Madison, Moderator

Walker Hall (40 physicians—by ticket only)

(5) "The Tonsil and Adenoid Problem"

JOHN R. LINDSAY, M.D., *Professor and Chief of Otolaryngology, University of Chicago School of Medicine,* Chicago, Illinois

Room 3, Sports Arena (40 physicians — by ticket only)

(6) "The Problems of Peptic Ulcer"

JOSEPH KIRSNER, M.D., Ph.D., *Professor of Medicine, University of Chicago School of Medicine,* Chicago, Illinois

JOSEPH SHAIKEN, M.D., Milwaukee, Moderator

Juneau Hall (40 physicians—by ticket only)

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SPECIAL PROGRAM BY YOUNG INTERNISTS

KILBOURN HALL, MILWAUKEE AUDITORIUM

Sponsored by the Wisconsin Society of Internal Medicine but open to all members of the State Medical Society. No advance reservations required. Participants are residents or research associates at the institution represented.

PAUL LABISSONIERE, M.D., Milwaukee, *Chairman of Postgraduate Education and Research Committee, Wisconsin Society of Internal Medicine,* Moderator

9:00 a.m.—"Auricular Fibrillation and Nodular Goiter"

BEATRICE BERTEAU, M.D.
Milwaukee County Hospital
(Sponsored by Drs. W. W. Engstrom and G. A. Hellmuth, Milwaukee)

9:20 a.m.—"Studies of Hemolytic Anemia Utilizing Radio-Chromium Labeled Red Cells"

LEE SCHLOESSER, M.D.
University Hospitals, Madison
(Sponsored by Drs. R. F. Schilling and J. L. Sims, Madison)

9:40 a.m.—"Diagnostic Kidney Biopsy Using the Vim–Silverman Needle"

WALTER H. THIEDE, M.D.
Veterans Administration Center, Wood
(Sponsored by Dr. J. J. Levin, Wood)

10:00 a.m.—Recess to View Exhibits

Don't Forget To Register At All Exhibits

GENERAL PROGRAM

JUNEAU HALL, MILWAUKEE AUDITORIUM

S. A. MORTON, M.D., Milwaukee, *Chairman, Council on Scientific Work,* Moderator

10:30 a.m.—"The Prevention of Rheumatic Fever —General Principles and Methods"

GENE STOLLERMAN, M.D., *Assistant Professor of Medicine, Northwestern University School of Medicine,* Chicago, Illinois

This presentation is a Lucy Droessel Memorial Lecture of the Wisconsin Heart Association.

Doctor Stollerman is a native of New York City; graduate of Columbia Medical School. He is principal investigator at the Sackett Foundation for Research in Rheumatic Fever and Allied Diseases. He recently prepared an audio-visual lecture for the American Heart Association on rheumatic fever. He is the author of the chapter on rheumatic fever in "Holt Pediatrics."

11:00 a.m.—"Ureteral and Bladder Injuries Following Pelvic and Colon Surgery"

MILTON COPLAN, M.D., *Clinical Professor, Division of Urology, Department of Surgery, University of Miami School of Medicine,* Miami, Florida

Graduate of Vanderbilt University Medical School. Former president of the staff of Jackson Memorial Hospital. Early contributor to research on urinary calculus disease and contributor of the first article on the "loop" catheter for extracting small calculi from the lower segment of the ureter. His paper will discuss management of 30 injuries including diagnosis for surgical correction.

11:30 a.m.—"The Uses and Limitations of the Newer Drugs in the Treatment of Nervous Conditions"

VERNON KINROSS-WRIGHT, M.D., *Anderson Department of Psychiatry, Baylor University College of Medicine,* Houston, Texas

This is a Rogers Memorial Lecture presented by Rogers Memorial Sanitarium, Oconomowoc.

A native of England and a graduate of London University in 1944. He received postgraduate training in psychiatry in various hospitals in England before receiving appointments in the psychiatric field in North Carolina starting in 1949. His paper discusses chlorpromazine, Rauwolfia deviations, Miltown, Equanil and other centrally acting drugs which appear to have a wide application in medicine. He points out a variety of unusual side effects which may be overlooked.

Thursday Noon

12:00 noon—Past Presidents' Luncheon
Parlor G, Schroeder Hotel

12:00 noon—Section on Ophthalmology & Otolaryngology Luncheon (members only)
East Room, Schroeder Hotel

Reservations through State Medical Society, Box 1109, Madison 1

Business meeting at 1:15 p.m., followed by open scientific program (see page 409).

12:00 noon—Wisconsin Urological Society Luncheon (members only)
Parlor A, Schroeder Hotel

Reservations through A. P. Graham, M.D., 117 W. Doty, Neenah

12:30 p.m.—Wisconsin Society of Internal Medicine Luncheon (members only)
Pere Marquette Room, Schroeder Hotel

Reservations through Mr. James Eiff, Suite 700, 208 E. Wisconsin Ave., Milwaukee 2

Outstanding Technical Exhibits—See Page 420

Thursday Afternoon

SPECIAL PROGRAM ON INTERNAL MEDICINE

JUNEAU HALL, MILWAUKEE AUDITORIUM

Open to all members of the State Medical Society

KARL DOEGE, M.D., Marshfield, *Chairman, Program Committee, Wisconsin Society of Internal Medicine,* Moderator

1:40 p.m.—"Mucoproteins in Rheumatic Fever in Children"
J. R. HEERSMA, M.D., Marshfield

2:00 p.m.—"The Relation of Group A Hemolytic Streptococci to the Rheumatic State"
GENE H. STOLLERMAN, M.D., *Assistant Professor of Medicine, Northwestern University School of Medicine,* Chicago, Illinois
(Sponsored by the Wisconsin Heart Association)

2:30 p.m.—"The Place of Cardiac Catheterization in the Diagnosis of Valvular Heart Disease"
JOHN HUSTON, M.D., Milwaukee

2:50 p.m.—Discussion of Dr. Huston's Paper
DRS. HELLMUTH and RASTETTER

3:00 p.m.—Recess to View Exhibits

JOHN L. SIMS, M.D., Madison, *Vice-Chairman, Program Committee, Wisconsin Society of Internal Medicine,* Moderator

3:45 p.m.—"The Management of Chronic Ulcerative Colitis"
JOSEPH B. KIRSNER, M.D., Ph.D., *Professor of Medicine, University of Chicago School of Medicine,* Chicago, Illinois

Native of Massachusetts and graduate of Tufts Medical College. President of the American Gastroscopic Society from 1949 to 1950. His paper will point out that management of ulcerative colitis remains symptomatic, individualized and prolonged. Medical treatment is indicated in 85 per cent of cases. He will discuss the use of antibiotics, hormones, diet and the indications for surgical treatment.

4:15 p.m.—"The Management of Acute Renal Insufficiency"
EARL SCHULZ, M.D., Milwaukee

4:30 p.m.—Discussion of Dr. Schulz's Paper
DRS. F. D. and T. R. MURPHY, Milwaukee

4:40 p.m.—Panel Discussion: "Coronary Disease"
CHESTER KURTZ, M.D., Madison
LESLIE KINDSCHI, M.D., Monroe
M. C. F. LINDERT, M.D., Milwaukee
T. O. NUZUM, M.D., Janesville
R. D. TAYLOR, M.D., Marshfield, Moderator

SPECIAL PROGRAM ON ANESTHESIA

KILBOURN HALL, MILWAUKEE AUDITORIUM

Prepared in cooperation with the Wisconsin Society of Anesthesiologists but open to all members of the State Medical Society.

MILTON DAVIS, JR., M.D., Madison, Moderator

2:00 p.m.—"Fundamental Errors in Anesthesia"
STUART CULLEN, M.D., *Professor of Surgery and Chairman of Division on Anesthesiology, State University of Iowa, University Hospitals,* Iowa City, Iowa

Graduate of the University of Wisconsin Medical School. Now a director of the American Board of Anesthesiology and associate editor of *Anesthesiology.* He will discuss the peculiar properties of depressant drugs, a means of applying them rationally and safely, and some of the hazards associated with their use. He will also discuss narcotic antagonists.

2:30 p.m.—"Respiratory Emergencies"
JOSEPH J. BUCKLEY, M.D., *Instructor, Department of Anesthesiology, University of Minnesota Medical School,* Minneapolis, Minnesota

Graduate of New York Medical College. He has been chief of the Section on Anesthesiology at the Veterans Hospital, Minneapolis, and is currently a consultant. A concise etiological outline of all types of respiratory emergencies will be presented. Emphasis will be placed upon accurate, rapid diagnosis. The basic physiologic disturbance associated with each problem will be discussed and the appropriate resuscitative measures will be outlined.

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—"Anesthesia in Relation to Cesarean Section"
STUART CULLEN, M.D., Iowa City
GEORGE HANK, M.D., Madison
JOSEPH J. BUCKLEY, M.D., Minneapolis
L. G. KILPATRICK, M.D., Madison, Moderator

Thursday Afternoon

SPECIAL PROGRAM ON UROLOGY

WALKER HALL, MILWAUKEE AUDITORIUM

Planned in cooperation with the Wisconsin Urological Society but open to all members of the State Medical Society.

JAMES J. KING, M.D., Milwaukee, *President, Wisconsin Urological Society,* Moderator

2:00 p.m.—"Localization of the Ectopic Ureteral Orifice"
A. M. SONNELAND, M.D., Madison

2:15 p.m.—"The Weak Bladder in Women"
BENJAMIN H. BRUNKOW, M.D., Monroe

2:30 p.m.—"The Effects of Hyaluronidase on Bladder Calculus Formation in Rats"
JOHN W. KEARNS, M.D., Milwaukee

2:45 p.m.—"Experiences With Radical Retropubic Prostatectomy"
H. W. CHRISTENSEN, M.D., Wausau

3:00 p.m.—Recess to View Exhibits

3:45 p.m.—Pyelogram Clinic
WALTER KEARNS, M.D., Milwaukee, Moderator

4:45 p.m.—Business Meeting (for members only)

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SPECIAL PROGRAM OF THE SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

EAST ROOM, SCHROEDER HOTEL

Prepared in cooperation with the Section on Ophthalmology and Otolaryngology but open to all members of the State Medical Society.

HERBERT G. SCHMIDT, M.D., Milwaukee, Presiding

2:15 p.m.—"Surgery of Intraocular Bodies"
CLEMENS KIRCHGEORG, M.D., Neenah

2:45 p.m.—(Topic to be announced)
ALSON E. BRALEY, M.D., *Professor of Ophthalmology, University of Iowa,* Iowa City, Iowa

3:30 p.m.—"The Operation for Stapes Mobilization"
JOHN R. LINDSAY, M.D., *Professor of Otolaryngology, University of Chicago School of Medicine,* Chicago, Illinois

Graduate of McGill University Medical School with resident and postgraduate training in Canada and Vienna. Chairman of E.N.T. Section, American Medical Association, 1955–56. Vice-President, American Otological Society, Inc., 1955–56. Doctor Lindsay will discuss the present status of the mobilization operation for relief in cases of fixation of the stapes for otosclerosis.

SPECIAL PROGRAM OF SECTION ON MEDICAL HISTORY

SOUTH ROOM, SCHROEDER HOTEL

Open to all interested physicians

WILLIAM D. STOVALL, M.D., Madison, Chairman, Presiding

2:00 p.m.—"Pioneer Leadership in Wisconsin Medicine"
MILLARD TUFTS, M.D., Milwaukee

Doctor Tufts will also present an exhibit of the papers of Ira Manley, M.D., Markesan, the 35th President of the State Medical Society, and Nicholas Senn, M.D., Milwaukee, who were close personal friends.

2:40 p.m.—"History with a Feminine Touch"
MRS. J. J. BOERSMA, Green Bay, *President, Woman's Auxiliary to the State Medical Society of Wisconsin*

3:00 p.m.—"The Doctor and Patient in Satire"
A series of Kodachromes
G. KASTEN TALLMADGE, M.D., Milwaukee, *Professor of the History of Medicine, Marquette University*

3:30 p.m.—Comments by the Chairman
"The Development of Medical Education in Wisconsin"
W. D. STOVALL, M.D., Madison

4:00 p.m.—Business Meeting

Join The Section On Medical History — Thursday

Thursday Evening

5:30 p.m.—President's Reception
East Room, Schroeder Hotel

All Society members and their ladies are invited to the reception for Dr. and Mrs. Ervin L. Bernhart. The reception will honor the conclusion of Doctor Bernhart's term as president of the State Medical Society.

6:00 p.m.—Wisconsin Society of Anesthesiologists Dinner (members only)
Medford Hotel
Reservations through George Kreuter, M.D., 5705 Oakhill Ave., Wauwatosa 13

6:00 p.m.—Wisconsin Urological Society Dinner (members only)
Milwaukee Athletic Club
Reservations through James King, M.D., Milwaukee

7:00 p.m.—Annual Dinner
Ballroom, Schroeder Hotel

The social highlight of the Annual Meeting honors physicians who have completed a half century of medical practice and receive engraved certificates attesting their membership in the 50 Year Club. The president-elect, Dr. L. O. Simenstad of Osceola, speaks briefly in assuming the presidency of the Society. The dinner concludes with an outstanding presentation of professional talent.

Hosts For Guest Speakers

The following physicians will serve as hosts for our guest speakers during their visit with us in Milwaukee

Guest	Host
RANDOLPH BATSON	J. C. PETERSON
A. E. BRALEY	DONALD HUGHSON
JOSEPH J. BUCKLEY	JOHN W. TEMPLE
J. G. BULGRIN	S. A. MORTON
FREDERICK COLLER	CARL EBERBACH
MILTON COPLAN	N. W. BOURNE and SIDNEY HURWITZ
STUART C. CULLEN	J. W. BOOKHAMER
JOHN E. FABER	L. T. SERVIS
M. M. FIGLEY	R. W. BYRNE
EDWARD A. GALL	JOSEPH F. KUZMA
ROBERT R. KIERLAND	DONALD M. RUCH
VERNON KINROSS-WRIGHT	JAMES CAFFREY
JOSEPH B. KIRSNER	JOSEPH SHAIKEN
WILLIAM B. KOUNTZ	VALORUS LANG
JOHN R. LINDSAY	HERBERT G. SCHMIDT
WILLIAM MENGERT	ROLAND S. CRON
HERBERT RATTNER	HARRY FOERSTER
GENE H. STOLLERMAN	LAMONT SCHWEIGER
GRANTLEY W. TAYLOR	JAMES CONLEY

SCIENTIFIC EXHIBITS

Wisconsin Physicians and Medical Groups Present a Visual Education Program

The Council on Scientific Work through Dr. Kenneth Lemmer is pleased to present the following scientific exhibits as a part of the Annual Meeting program, May 1–2–3. Physicians are urged to utilize recess periods and other free time for review of the material provided through the cooperation of the various individuals and agencies listed:

1. NON-TUBERCULOUS CHEST DISEASES

Veterans Administration Hospital, Madison, Wisconsin, (B. C. Taylor, M. D.)

This exhibit will consist of five panels, each representing a case history which will depict hospital care, x-rays, pre- and postoperative (if surgery is performed) and gross and microscopic pathology sections. The diagnosis will be given at the bottom of the panel, revealed by pushing a button to light up the diagnosis. Make your own diagnosis and see how you score.

2. (a) KINESCOPE DISPLAY

Wisconsin Division, American Cancer Society

This will show professional films available through the American Cancer Society suitable for showing at hospital staff conferences, county medical society meetings, etc.

2. (b) MILWAUKEE CANCER DIAGNOSTIC CLINIC, INC.

Milwaukee Division, American Cancer Society

The theme of this display will be to point out the results of diagnostic studies in 1500 cases examined. This will be presented against a background of information as to how the Clinic operates.

X-rays, artist drawings of gastroscopic and proctoscopic views, gross and microscopic pathologic slides will be arranged to highlight the clinical information pertaining to CA of the Breast, CA of the Stomach, CA of the Cervix, CA of the Colon and Rectum, and malignant polyps.

3. STAFF OF COLUMBIA HOSPITAL, MILWAUKEE

This exhibit will set forth some of the teaching and investigational activities of the staff.

4. ELECTIVE PLASTIC SURGERY OF THE FACE

Frank D. Bernard, D. D. S., M. D., Madison, Wisconsin

This exhibit will include surgical treatment of congenital and acquired deformities of the face.

5. (Title in Final Program)

Milwaukee Hospital Clinical Staff

6. TUMORS OF THE SMALL INTESTINE

Marquette University School of Medicine (Drs. J. F. Kuzma and Leo R. Weinshel)

This exhibit will show the experience with small bowel tumors which were encountered over the course of many years. The clinical-pathological correlation of the tumors is to be made. It is planned to have fourteen by seventeen translight clinical data correlated with gross and microscopic colored transparencies of the lesions.

7. ACUTE CHOLECYSTITIS: SIGNS AND SYMPTOMS, PATHOLOGY AND TREATMENT

Marquette University and Milwaukee County Hospital (Dr. David W. Barrow, Milwaukee)

This exhibit will consist of charts, pictures, and slides showing the incidence, etiology, pathology, and treatment in patients with acute cholecystitis.

8. CARDIOVASCULAR SURGICAL TECHNIQUE — "OPEN" CARDIAC SURGERY

St. Luke's Hospital, Milwaukee (Henry F. Twelmeyer, M. D.)

A simple oxygenator and pump devised to bypass the heart for open cardiac surgery will be illustrated. This is based on the equipment developed at the University of Minnesota.

9. NEUROSURGICAL DIAGNOSIS AND TREATMENT OF BRAIN TUMORS

St. Luke's Hospital, Milwaukee (Drs. J. D. Levin, W. J. Blake and C. E. Schmidt, and Mr. Adam Tomes)

This exhibit will consist of documentation of eight cases of brain tumors treated at St. Luke's Hospital. It will include clinical histories, x-rays, E.E.G.'s microphotographs and angiograms.

10. LATEST DEVELOPMENTS IN UPPER EXTREMITY PROSTHETICS

E. C. Welsh, M. D., Columbia Hospital, Milwaukee, and Henry Okagaki, M. D., University of Wisconsin Medical School, Madison

This will consist of a demonstration showing the proper fitting of prosthetics and upper extremity amputations. In addition to the sponsoring physicians there will be certified limb makers and physical therapists who will assist in the demonstration. The demonstrations will be held only during the recess periods in the morning and afternoon.

11. ARTHRITIS REGISTRATION AND ARTHRITIS EXPOSED

Wisconsin Chapter, Arthritis and Rheumatism Foundation, Milwaukee

This exhibit will describe the activities and services of the Arthritis Foundation with special emphasis on the Arthritis Registration Program and the availability of the book "ARTHRITIS EXPOSED." It will also touch on services of the Physical Therapy Mobile Unit in Milwaukee and the plans for clinics and research in cooperation with the University of Wisconsin and Marquette University Medical Schools.

12. THE MULTIPLE ROLE OF THE MODERN TB HOSPITAL

Wisconsin Anti-Tuberculosis Association, Milwaukee

The modern sanatorium for the treatment of tuberculosis aims to be a hospital. Wisconsin physicians have used these facilities for the isolation and treatment of this infectious disease. Therapy in the last nine years has included the use of drugs and resectional surgery. Immediate results have been excellent.

The State Medical Society through its Division on Tuberculosis and Chest Diseases also has endorsed the sanatorium as a place to educate the patient with tuberculosis. The patient must be taught a proper mode of life. He must learn to protect others from this infection. The sanatorium with its modern x-ray equipment ond bacteriological culture laboratory, under competent medical direction, can well aid the practicing physician in the diagnosis and treatment of his tuberculous patient. These and other roles of the sanatorium have helped develop it as a modern TB hospital.

13. PREVENTIVE MEASURES IN THE MANAGEMENT OF HEMIPLEGIA

Ray Piaskoski, M. D., Veterans Administration Hospital, Wood

This exhibit illustrates by means of photographs various physical medicine procedures employed in preventing the common deformities frequently associated with hemiplegia. These deformities are usually the result of improper body positioning, prolonged bed rest. and spastic muscle groups. The exhibit is divided into three sections dealing wth the bed phase, wheel chair phase, and ambulatory phase. Various simple, easily made devices as well as physical treatments are illustrated. Most of the program shown can be easily employed in the management of hemiplegics at home or in smaller hospitals where trained therapists arc not available.

14. NEUROLOGY SERVICE IN A GENERAL HOSPITAL

Drs. Max Primakow, E. A Niles, B. S. Schaeffer, and Francis J. Millen, Veterans Administration Hospital, Wood

15. SURGICAL ANATOMY IN PULMONARY RESECTIONS

Drs. Wilson Weisel, Raymond R. Watson, Derwood Lepley, Howard L. Kuhl, and Donald P. Davis, Veterans Administration Hospital, Wood

This exhibit, having to do with the surgical anatomy encountered in resections of the lung, is designed to present accurate paintings originally sketched at the operating table. In addition special injected specimens of lungs have been prepared so that they may be handled and viewed at close range for careful determination of the detailed hilar and sub-hilar surgical anatomy of the lung.

16. GROSS TISSUE DEMONSTRATIONS

Section on Pathology and the Wisconsin Society of Pathologists

Fixed and fresh gross pathological specimens will be demonstrated by various pathologists.

17. LUMBAR SYMPATHECTOMY

Henry M. Suckle, M. D., Madison

This exhibit is designed to demonstrate the aims, the contraindications and results of lumbar sympathectomy. The major diagnostic points providing indications for the operative procedure are not only listed, but also illustrated. Lumbar sympathetic block as a diagnostic measure is fully illustrated and the operative procedure of lumbar sympathectomy with anatomical and surgical drawings is fully illustrated.

18. THE PREVENTION OF RHEUMATIC FEVER

Wisconsin Heart Association, Milwaukee

This exhibit will serve as an adjunct to the main Wisconsin Heart Association exhibit on research which will be presented at the 1956 meeting of the State Medical Society of Wisconsin. Among other things, the prevention exhibit shows in enlarged form the bacteria, hemolytic streptococci, as it appears on a sheep blood agar plate. Also of interest will be the presentation of a simplified office method of checking cultures for beta hemolytic streptococcus.

19. BLOOD VESSEL GRAFTS

Milwaukee County Medical Society and Veterans Administration Hospital, Wood, Wisconsin (Drs. James M. Sullivan, Milwaukee, James Conley, Milwaukee, and Ned Maxwell, Milwaukee)

This exhibit will be in three sections. The first section will illustrate the organization, procurement and processing involved in obtaining blood vessel grafts and there will be a demonstration of freeze-drying equipment. The second section will give the indications and objectives in blood vessel grafting plus methods of diagnosis. The third section will give illustrative cases in which blood vessel grafts may be used.

19a. HISTOPLASMOSIS DETECTED AMONG ROUTINE CHEST CLINIC REFERRALS

Beloit Health Department (J. C. Springberg, M. D., Health Commissioner)

A review of unusual cases of histoplasmosis encountered in a community health program, which illustrates the productive results of routine chest clinic referrals.

20. BLOOD DERIVATIVES THROUGH THE RED CROSS BLOOD PROGRAM

Badger Regional Blood Center, Madison (Merle Owen Hamel, M. D.)

This display presents material on blood derivatives available through the Red Cross Blood Program, with specimens of the products and pictures of their uses. Included are fresh frozen plasma, red cell mass, serum albumin, gamma globulin, and fibrinogen.

21. U. S. NAVAL DENTAL CORPS CASUALTY TREATMENT TRAINING PROGRAM

Dental Division, Bureau of Medicine and Surgery, Department of the Navy

This exhibit illustrates various phases of the casualty treatment training program for naval dental officers.

Featured in the exhibit are some of the training aids developed by the Naval Dental School at Bethesda, Maryland, to develop skill and dexterity in treating casualties. One outstanding feature is a model of a military casualty fitted wth several types of moulages simulating different injuries. The viewer is challenged to decide how he would handle the injuries. When the exhibit is displayed, the accepted type of emergency treatment is demonstrated at appropriate intervals.

22. FOREIGN BODIES IN THE EYE

Jackson Clinic, Madison (Everet H. Wood, M. D.)

This exhibit will consist of a simulated ophthalmic treatment office, with treatment chair, treatment table, light and a display of the necessary instruments for taking care of foreign bodies of the eye. Exhibit will be illustrated by various plaques containing pictures of eyes with foreign bodies, methods of getting these foreign bodies in the eye, illustrations of treatment, x-rays of intraocular foreign bodies, and some illustrations of the disastrous results which may occur if the foreign body is poorly treated. These illustrations will be explained by appropriate printed matter adjacent to the pictures.

SPECIAL EDUCATIONAL EXHIBITS IN FIFTH STREET FOYER ADJACENT TO MEETING HALLS

OPPORTUNITIES IN THE U. S. PUBLIC HEALTH SERVICE

U. S. Public Health and State Board of Health

This exhibit describes briefly the role of the Public Health Service in the areas of clinical medicine, research, and preventive health services. It utilizes opportunities for careers in the Public Health Service or for professional service in national emergencies.

THE MENTALLY RETARDED CHILD, HIS PHYSICIAN AND HIS SCHOOL

State of Milwaukee Health Department

This exhibit outlines services to mentally retarded children developed in the Milwaukee school system. The material would be of great interest to general practitioners who are encountering more and more frequently problems in connection with retarded children brought to them by parents.

SERVICES TO THE BLIND

Division of Public Assistance, State Department of Public Welfare

This exhibit will consist of representative equipment used by the blind or used for instruction of the blind together with descriptive leaflets and selected photographs of blind workers. It will include Braille writing equipment, specially adapted measurement devices, optical aids for subnormal vision, a Talking Book machine and records. Leaflets will describe services in detail.

AMERICAN PHYSICAL THERAPY ASSOCIATION

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

This exhibit will explain one of the most recent organizations to be established in the paramedical field. The medical assistants society will try to acquaint physicians with their organization and will distribute information for the physicians' office assistants. Arrangements have been made for desk and typewriter, and a medical assistant will be on hand to take dictation, notes, letters, and the like for physicians who wish this or other services performed.

Things To Remember

Make up a party for Gemutlichkeit Night, Tuesday, May 1 . . . refreshments "on the house."

★

Don't miss the Visible Tumor Clinic at 4:15 p.m., Tuesday, May 1. First of its kind anywhere.

★

These specialty programs are open to all members of the Society:

Surgery—Wednesday

Obstetrics and Gynecology—Wednesday

Radiology—Wednesday

Pathology—Wednesday

Internal Medicine—Thursday

Ophthalmology and Otolaryngology —Thursday

Anesthesia—Thursday

Urology—Thursday

★

Be sure to attend at least one session of the House of Delegates: Tuesday or Wednesday evening, and Thursday morning.

★

An unusual program on Medical History is scheduled for 2 p.m., Thursday, May 3.

★

You'll find something new in the Scientific and Technical Exhibits. Don't miss them.

Summary Of Refresher Courses

(Admission by Ticket Only—Limit of 40 Per Course)

Tuesday, May 1—General Practice Day

1. "THE MAINTENANCE OF HEALTH OF THE GERIATRIC PATIENT"
   William B. Kountz, M. D., St. Louis
2. "DRUGS AND MALIGNANCY"
   Harry Beckman, M. D., Milwaukee
3. "THE USES AND ABUSES OF STEROIDS IN DERMATOLOGY"
   Robert Kierland, M. D., Rochester
   Donald M. Ruch, M. D., Milwaukee, Moderator
4. "RECENT DEVELOPMENTS IN THE DIAGNOSIS AND TREATMENT OF POLIOMYELITIS"
   Randolph Batson, M. D., Nashville
   Peter Wisniewski, M. D., Milwaukee
   J. C. Peterson, M. D., Milwaukee, Moderator
5. "LESIONS OF THE ANUS, RECTUM AND COLON"
   Frederick A. Coller, M. D., Ann Arbor
   Carl Eberbach, M. D., Milwaukee, Moderator

★

Wednesday, May 2

1. "PROLONGED LABOR"
   William Mengert, M. D., Chicago
   Carlton Wirthwein, M. D., Milwaukee, Moderator
2. "MANAGEMENT OF BENIGN AND MALIGNANT LESIONS OF THE BREAST"
   Grantley W. Taylor, M. D., Boston
   James Conley, M. D., Milwaukee, Moderator
3. "OFFICE OPHTHALMOLOGY"
   Peter Duehr, M. D., Madison
4. "EMERGENCY TREATMENT OF HAND INJURIES"
   Frank D. Bernard, D.D.S., M. D., Madison
5. "HOW TO HANDLE THE NEWER ANTIBIOTICS IN PULMONARY LESIONS"
   Elwood W. Mason, M. D., Milwaukee
6. "CONTRAST EXAMINATION OF THE CARDIOVASCULAR SYSTEM"
   M. M. Figley, M. D., Ann Arbor

★

Thursday, May 3

1. "EMERGENCY TREATMENT OF HEAD INJURIES"—A Panel:
   Harry Maxwell, M. D., Milwaukee, Moderator
   Henry Suckle, M. D., Madison
   Ray Quade, M. D., Neenah
2. "RECOGNITION AND TREATMENT OF TOXIC PSYCHOSES"
   Vernon Kinross-Wright, M. D., Houston
   James Caffrey, M. D., Milwaukee, Moderator
3. "HEMATURIA"
   Milton Coplan, M. D., Miami
   N. W. Bourne, M. D., Milwaukee, Moderator
4. "THE USE OF DEPRESSANT DRUGS"
   Stuart Cullen, M. D, Iowa City
   Milton Davis, Jr., M. D., Madison, Moderator
5. "THE TONSIL AND ADENOID PROBLEM"
   John R. Lindsay, M. D., Chicago
6. "THE PROBLEMS OF PEPTIC ULCER"
   Joseph Kirsner, M. D., Ph.D., Chicago
   Joseph Shaiken, M. D., Milwaukee, Moderator

Don't Miss Gemütlichkeit Night

HOTEL SCHROEDER, TUESDAY, MAY 1, AT 8:30 P. M.

CRYSTAL BALLROOM

Fun!!! No Cover Charge Fun!!!

Dancing . . . Music . . . Floor Show

An entirely new innovation climaxes General Practice Day at the 1956 Annual Meeting. Dancing to Steve Swedish and his Orchestra in the Crystal Ballroom.

The Ballroom will be set up in "nite club" style with continuous music, dancing and entertainment. Adding to the festivities will be the talents of Wisconsin physicians and Auxiliary members whose novelty numbers will be interspersed with presentations by professional entertainers.

BE SURE TO ATTEND . . . NO COVER CHARGE . . . FUN GALORE

Annual Dinner

HOTEL SCHROEDER, THURSDAY, MAY 3, 7:00 P. M.

PRESENTATION OF GAVEL: The official badge of office is presented by incoming president L. O. Simenstad to President Ervin L. Bernhart as a token of his service.

HONORS TO NEW MEMBERS OF "50 YEAR CLUB": The following members will be granted certificates and pins as newly qualified members of the Club in recognition of a half century of medical practice:

R. G. ARVESON, M. D.----------Frederic
FREDERICK BAUER, M. D.----------Shawano
FRANK O. BRUNCKHORST, M. D.----------Neenah
VIRGIL D. CRONE, M. D.----------Beloit
CHARLES FIDLER, M. D.----------Milwaukee
A. A. HOYER, M. D.----------Beaver Dam
J. F. McNARY, M. D.----------Milwaukee
WILL G. MERRILL, M. D.----------Ashland
DANIEL F. NAUTH, M. D.----------Kiel
ROLLAND G. RAYMOND, M. D.----------Brownsville
JOSEPH F. ROSE, M. D.----------Lena
FREDERICK W. SEEGERS, M. D.----------Milwaukee
PAUL C. WAGNER, M. D.----------Milwaukee

FLOOR SHOW: Professional entertainment of unusually high caliber will be presented immediately following the short ceremonies above. There will be two hours of fine music, dancing, singing, acrobatics and variety talent. The program will conclude at 10:00 p. m.

YOU CAN ORDER TICKETS NOW . . . $6.00 PER PLATE . . . LIMITED TO 450 RESERVATIONS

1956 Auxiliary Convention Program

Tuesday, May 1

P.M.

4:00 Registration, Fifth Floor, Hotel Schroeder

MRS. BOERSMA

Those who attend: State Officers, State Chairmen, County Presidents and Presidents-Elect, Past State Presidents and Honored Guests.

(Dress, semiformal)

6:30 Board of Directors' Dinner, English Room, Hotel Schroeder

8:30 Gemütlichkeit Night, Ballroom, Hotel Schroeder

Wednesday, May 2

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

10:00 Formal Opening of the Twenty-Eighth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

Mrs. J. J. Boersma, President, presiding

Invocation—Dr. Thomas Lyter, Pastor, Washington Park Presbyterian Church, Milwaukee

Acceptance of Agenda

Pledge to Flag—Mrs. J. G. Jamieson, Racine

Pledge of Loyalty—Mrs. J. G. Jamieson, Racine

Introduction of Officers and Honored Guests

Address of Welcome

Response—Mrs. R. T. Schmidt, Green Bay

Convention Announcements—Mrs. G. A. Behnke, Kaukauna

Convention Rules of Order—Mrs. M. J. Reuter, Milwaukee

Roll Call—Mrs. D. L. Williams, Madison

Minutes of Twenty-Seventh Meeting—Mrs. D. L. Williams, Madison

Address of President—Mrs. J. J. Boersma

Reports of County Presidents (Time limit—2 minutes)

Report on Registration—Mrs. W. S. Giffin, Appleton

P.M.

12:00 Coffee Break

12:30 Meeting reconvenes

. . . Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

2:30 May Day Salad Luncheon and Fashion Show Gimbels' Main Dining Room

MRS. FLANDERS

. . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

7:00 Buffet Supper, Crystal Ballroom, Hotel Schroeder

In honor of Mrs. Robert Flanders, Manchester, N. H., President-Elect, Woman's Auxiliary to the American Medical Association

Thursday, May 3

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

10:00 Business Session, Crystal Ballroom, Hotel Schroeder

Mrs. J. J. Boersma, President, presiding

Convention Announcements—Mrs. G. A. Behnke

Memorial Service—Mrs. J. W. Boren, Jr., Marinette

Report of Nominating Committee — Mrs. V. S. Falk, Edgerton

Election of Officers

Installation of Officers—Mrs. Robert Flanders

Presentation of President's Pin

Inaugural Address—Mrs. H. W. Christensen, Wausau

Final Report on Registration—Mrs. W. S. Giffin

11:30 Post-Convention Board Meeting, Crysta Ballroom, Hotel Schroeder

Mrs. H. W. Christensen, President, presiding

P.M.

1:00 Luncheon, Crystal Ballroom, Hotel Schroeder
In honor of County Presidents of 1955–56 and a salute to the newly organized Wood and Lincoln County auxiliaries

Mrs. H. W. Christensen, President, presiding

A Message from National—Mrs. Robert Flanders, President-Elect, Woman's Auxiliary to the American Medical Association

Public Relations for Volunteer Service Organizations

Mrs. Jessie Cartwright, Home Service Director, Norge Division of Borg–Warner Company

. . . Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Hotel Schroeder

MRS. CHRISTENSEN

6:30 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

Convention Hostesses

WOMAN'S AUXILIARY TO THE OUTAGAMIE COUNTY MEDICAL SOCIETY

Front row, left to right: Mrs. F. M. Hauch, Mrs. M. S. Kagen, Mrs. Robert DeCock.

Second row, left to right: Mrs. H. T. Gross, Mrs. W. S. Giffin, Mrs. E. J. Zeiss, Mrs. G. A. Behnke, Mrs. L. B. McBain.

Third row, left to right: Mrs. E. F. Mielke, Mrs. W. J. Frawley, Mrs. F. S. Marshall, Mrs. D. W. Curtin.

HOUSE OF DELEGATES—1956

EAST ROOM, HOTEL SCHROEDER—Tuesday, May 1, 6:30 p. m., First Session—Wednesday, May 2, 7:30 p. m., Second Session—Thursday, May 3, 8:30 a. m., Third Session

SPEAKER: J. W. Fons, M. D., Milwaukee—VICE-SPEAKER: H. J. Kief, M. D., Fond du Lac

FIRST DISTRICT

Counties	Delegates	Alternates
DODGE	L. E. Schrank	H. G. Bayley
JEFFERSON	F. A. Gruesen	R. W. Quandt
WAUKESHA	Joseph Bartos	James Bolger

SECOND DISTRICT

KENOSHA	D. N. Goldstein	H. Schwartz
RACINE	G. J. Schulz	R. J. Schacht
	L. O. Mastalir	J. D. Postorino
WALWORTH	E. D. Sorenson	E. D. Hudson

THIRD DISTRICT

COLUMBIA–MARQUETTE–ADAMS	J. H. Houghton	R. F. Inman
DANE	J. R. Steeper	R. A. Straughn
	M. T. Morrison	V. W. Nordholm
	T. W. Tormey, Jr.	R. M. Becker
	C. W. Stoops, Jr.	R. P. Sinaiko
	G. C. Hank	R. J. Hennen
	A. A. Quisling	E. J. Nordby
	P. B. Golden	A. P. Schoenenberger
GREEN	B. H. Brunkow	J. R. Weir
ROCK	H. E. Kasten	W. S. Freeman
	M. D. Davis	J. D. Schroeder
SAUK	B. E. McGonigle	C. R. Pearson

FOURTH DISTRICT

CRAWFORD	T. F. Farrell	O. E. Satter
GRANT	M. W. Randall	E. C. Howell
IOWA	C. L. White	S. B. Marshall
LAFAYETTE	L. L. Olson	D. J. Garland
RICHLAND	D. J. Taft	R. E. Housner

FIFTH DISTRICT

CALUMET	E. W. Humke	A. C. Engel
MANITOWOC	R. G. Yost	N. A. Bonner
SHEBOYGAN	P. B. Mason	F. A. Nause
WASHINGTON–OZAUKEE	E. C. Quackenbush	P. B. Blanchard

SIXTH DISTRICT

BROWN–KEWAUNEE–DOOR	L. C. Miller	J. A. Ford
	R. M. Waldkirch	S. L. Griggs
FOND DU LAC	H. J. Kief	Howard Mauthe
OUTAGAMIE	G. W. Carlson	H. T. Gross
WINNEBAGO	David Regan	R. F. Wagner
	George Schwei	W. V. Hahn

SEVENTH DISTRICT

TREMPEALEAU–JACKSON–BUFFALO	R. L. MacCornack	B. C. Dockendorff
LA CROSSE	R. L. Gilbert	J. P. McCann
MONROE	D. C. Beebe	Judson Allen
VERNON	R. S. Hirsch	F. F. Gallin
JUNEAU	J. E. Thompson	V. M. Griffin

EIGHTH DISTRICT

MARINETTE–FLORENCE	C. E. Koepp	J. W. Boren, Jr.
OCONTO	H. A. Aageson	Gilbert Sandgren
SHAWANO	H. C. Marsh	Donald Jeffries

NINTH DISTRICT

Counties	Delegates	Alternates
CLARK	M. V. Overman	R. L. Hansen
GREEN LAKE–WAUSHARA	V. J. Taugher	R. Wichman
LINCOLN	R. G. Baker	K. A. Morris
MARATHON	D. M. Green	E. P. Ludwig
PORTAGE	R. H. Slater	J. R. Erickson
WAUPACA	Marshall Boudry	W. McInnis
WOOD	R. W. Mason	H. G. Pomainville

TENTH DISTRICT

BARRON–WASHBURN–SAWYER–BURNETT	J. R. Guy	R. C. Thompson
CHIPPEWA	W. C. Henske	J. J. Sazama
EAU CLAIRE–DUNN–PEPIN	Robert Lotz	O. Moland
PIERCE–ST. CROIX	P. H. Gutzler	O. H. Epley
POLK	L. O. Simenstad	V. C. Kremser
RUSK	H. F. Pagel	J. E. Murphy

ELEVENTH DISTRICT

ASHLAND–BAYFIELD–IRON	J. W. Prentice	J. M. Jauquet
DOUGLAS	C. J. Picard	N. A. Sincock

TWELFTH DISTRICT

MILWAUKEE	A. J. Baumann	E. A. Habeck
	J. B. Wilets	R. E. Callan
	R. F. Purtell	D. W. Ovitt
	S. L. Chojnacki	S. E. Zawodny
	P. J. Niland	R. T. McCarty
	A. J. Martin	A. J. Sanfelippo
	D. M. Willson	M. C. F. Lindert
	John Beffel	C. M. Schroeder
	S. A. Morton	E. M. End
	I. J. Ricciardi	J. F. Cary
	F. E. Drew	E. G. Collins
	W. J. Houghton	R. H. Lillie
	G. W. Hilliard	R. A. Nimz
	E. R. Daniels	Owen Royce
	M. S. Fox	F. J. Krueger
	J. E. Conley	S. M. Feld
	H. J. Lee	G. C. Owen
	G. E. Collentine, Jr.	T. R. Murphy
	Joseph Shaiken	D. S. Thatcher
	H. P. Maxwell	W. A. Brah

THIRTEENTH DISTRICT

FOREST	E. F. Castaldo	B. S. Rathert
LANGLADE	B. W. Beattie	----------
ONEIDA–VILAS	Marvin Wright	I. E. Schiek, Sr.
PRICE–TAYLOR	J. D. Leahy	W. E. Niebauer

SECTIONS

Section	Delegate	Alternate
GENERAL PRACTICE	Carl Fosmark	George Benish
INTERNAL MEDICINE	R. A. Frisch	R. N. Allin
NEUROLOGY and PSYCHIATRY	Harry Tabachnick	E. Madison Paine
OBSTETRICS and GYNECOLOGY	F. J. Hofmeister	W. O. Paulson
OPHTHALMOLOGY and OTOLARYNGOLOGY	E. J. Zeiss	H. C. High, Jr.
ORTHOPEDICS	D. W. McCormick	F. G. Gaenslen
PATHOLOGY	Gorton Ritchie	R. S. Haukohl
PEDIATRICS	G. H. Wegmann	Kenneth Winters
PUBLIC HEALTH	C. K. Kincaid	----------
RADIOLOGY	W. T. Clark	R. L. Troup
SURGERY	J. M. Sullivan	M. G. Rice
UROLOGY	J. W. Sargent	R. S. Irwin

THE TECHNICAL EXHIBITS

Without the support of the firms listed on the following pages, we could not afford an Annual Meeting without a registration fee of $10 or more. To what extent these organizations will continue to support our meeting is dependent upon the interest shown by physicians in attendance.

It will be appreciated if you will make a special effort to visit the exhibits during the intermission periods provided and to *register* at booths with products of special interest to you. This evidence of interest will provide us with funds so that outstanding speakers can be secured for future programs.

Your cooperation will be appreciated.

Booth — Company and Products

42—Abbott Laboratories, North Chicago, Ill.

Abbott Laboratories will exhibit Filmtab *Erythrocin*(R) and *Selsun*(R) Sulfide Suspension. *Erythrocin* (Erythromycin Stearate, Abbott) is a direct-acting antibiotic with specific action against cocci infections and little risk of side effects.

Selsun (Selenium Sulfide, Abbott) is a preparation for the control of seborrheic dermatitis of the scalp as well as common dandruff.

85—American Hospital Supply Corporation, Evanston, Ill.

Our exhibit will present a display of Travert-Electrolyte Solutions, the new Therapeutic Vitamin B Solution "Trinidex," and other Baxter parenteral therapy equipment, including the "Flashball" for simple needle insertion and the R-48 blood pump and administration set.

87—Ames Company, Inc., Elkhart, Ind.

Clinistix—new enzyme-impregnated test paper for determining glycosuria. This completely new principle in sugar testing insures utmost simplicity and convenience in use, complete specificity, extreme sensitivity, and qualitative accuracy.

Clinitest, for urine sugar analysis, is standardized. This assures accurate quantitative estimates whenever and wherever a test is performed—office, ward, clinic, or patient's home.

117—Audio-Digest Foundation, Glendale, Calif.

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast"—compiled and reviewed by a professional board of editors—may be heard in the physician's automobile, home, or office. The Foundation also offers medical lectures by nationally recognized authorities.

31—Ayerst Laboratories, Chicago, Ill.

Our exhibit will feature *Cytoferin*—the logical combination for iron therapy. Physicians are cordially invited to visit our booth to discuss *Cytoferin* and other Ayerst specialties which may be of interest to them.

93—Baby Development Clinic, Chicago, Ill.

The Baby Development Clinic offers demonstration material, both products and literature, helpful in instructing prospective parents in the physical and emotional aspects of the parent-child relationship arising out of daily care of their infants and children. We also have aids to assist parents in providing emotional security for their children through the school ages.

Booth — Company and Products

45—The Baker Laboratories, Inc., Cleveland, Ohio

Baker's Modified Milk and *Varamel*, two successful products for infant feeding, will be on display. Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins, and other important factors which help to eliminate many of the problems in modern infant feeding.

126—Barr X-Ray Company, Inc., Milwaukee

Once again we welcome our friends of the Medical Society. Our staff will be on hand to show you the latest x-ray accessories and supplies. If you have any x-ray problems to discuss, we shall try to help you. If not, stop by, relax, and just visit with us.

97—Beech-Nut Packing Company, New York, N. Y.

The Beech-Nut exhibit will feature a new line of Junior products particularly suitable for adult and toddler meals. The nutritionists will have material of interest on use of baby foods for geriatric feeding and feeding the allergic infant.

40—N. P. Benson Optical Company, Minneapolis, Minn.

We will show the latest styles, including custom-designed and imported frames, with color combinations obtained through the new Colorfuse procedure. There will be samples of complicated lens Rx's, complete style room and dispensing room furniture and equipment, and complete Catarex lens service.

23—House of Bidwell, Inc., Milwaukee

We have for your inspection an array of prosthetic, orthopedic, and surgical appliances. Of special interest will be the showing of Dr. Jewett's Hyperextension Back Brace. You are also cordially invited to visit our facilities located at 535 North 27th Street to see the actual fabrication of artificial limbs and orthopedic appliances.

86—Bilhuber-Knoll Corporation, Orange, N. J.

Oral *Metrazol* is indicated for the aged patient where senile confusion, convalescence, or fatigue are present. New information and literature on this therapy is available. Information concerning the use of *Tensodin* in coronary disease as well as *Dilaudid*, *Bromural*, *Quadrinal*, *Theocalcin*, and the other Bilhuber chemicals is also available. You are invited to discuss these preparations with our representatives.

26—The Borden Company, Prescription Products Division, New York, N. Y.

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Bor-

Booth Company and Products

den's infant formula products for every feeding purpose or preference. You can feed almost any baby *Bremil, Mull-Soy* (Liquid or Powered), *Dryco,* or *Biolac.*

30—Brook Hill Farms, Inc., Chicago, Ill.

Samples of all Brook Hill dietary milks will be served. These include *Enzylac* (enzyme treated milk for easier digestibility), *Fat Free Enzylac, Bac-T* (sweet skimmed acidophilus milk), *Kazol-Acidophilus Buttermilk, Super-Cams,* (super concentrate of acidophilus) and *Dari-Vi* (homogenized, hypo-allergic multi-vitamin liquid).

39—Brooks Appliance Company, Chicago, Ill.

We will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated *Primer Bandage* and the *Dalzoflex Elastic Adhesive Bandage,* which are used in treating leg ulcers and phlebitis, will be shown. Elastic stockings, the *Nulast Elastic Crepe Bandages,* and surgical supports will also be displayed.

27—Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

New Products: The extensive research facilities of "B. W. & Co.," both here and in other countries, are directed to the development of improved therapeutic agents and techniques. Through such research "B. W. & Co." has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system, and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs. Our staff will welcome the opportunity to discuss our products and latest developments with you.

92—Carnation Company, Los Angeles, Calif.

Carnation Company presents Carnation Instant Nonfat Dry Milk Solids, the *first* and only true instant nonfat dry milk. The "Magic Crystals" process, which has resulted in instant solubility and fresh flavor, has won the 1955 Food Engineering Award for the year's major advance in food processing. We cordially invite you to sample this fine product—an excellent, economical source of protein.

121—The Central Pharmacal Company, Seymour, Ind.

Our exhibit will feature members of the *Neocylate* family of potentiated salicylate products. In addition to *Neocylate, Neocylate w/Colchicine, Neocylate w/Cortisone,* and *Neocyten,* the newest addition to this group of products—*Neocydex*—will be presented. Literature and samples of these specialties will be available at our booth.

43—Chicago Pharmacal Company, Chicago, Ill.

Chimedic specialities featured are: *Vermizine,* the clinically proven vermifuge with the pleasant strawberry taste, for thorough eradication of pinworms and roundworms; *Tolyspaz & Tolyphy,* wide-range spasmolysis formulas in tablet and liquid form; *Urised,* nationally known urinary antiseptic and sedative tablet; plus a complete quality line in injectables, ointments, and liquids awaiting your inspection.

52—Chicago Reference Book Company, Chicago, Ill.

70—Ciba Pharmaceutical Products Inc., Summit, N. J.

Ciba is featuring two prescription specialties—*Ritalin,* a new mild stimulant-antidepressant, and *Doriden,* a nonbarbiturate hypnotic-sedative. *Ritalin* raises depressed patients to normal levels of psychomotor activity without amphetamine-like overstimulation or depressive rebound. Nonhabit-forming *Doriden* is already being widely used as a safe barbiturate replacement. Representatives will be present to answer queries on these very effective agents.

Booth Company and Products

74—Coca-Cola Bottling Company, Milwaukee

Pause—and refresh yourself during your visits to the Exhibit Hall.

65—Joseph E. Dahl Company, Minneapolis, Minn.

66—Desitin Chemical Company, Providence, R. I.

Desitin Ointment, the pioneer in external cod liver oil therapy. Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids, and fissures.

Desitin Powder, a unique, dainty medicinal powder saturated with cod liver oil.

Desitin Hemorrhoidal Suppositories with Cod Liver Oil, coats anorectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.

Desitin Lotion, the original cod liver oil lotion; soothing, protective, mildly astringent and healing, in nonspecific dermatitis, pruritis, poison ivy, etc.

83—Doerflinger Artificial Limb Company, Milwaukee

Our display will be orthopedic and prosthetic appliances, including the latest improvements for both upper and lower extremities. The *Otto Bock Safety Knee,* for above-knee amputees, is outstanding.

16—Doho Chemical Corporation, New York, N. Y.

We will exhibit *Auralgan,* the ear medication for the relief of pain, otitis media and removal of cerumen; new *Otosmosan,* the effective, nontoxic ear medication which is fungicidal and bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears; and *Rhinalgan,* the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, will feature *Rectalgan,* the liquid topical anesthesia, also for the relief of pain and discomfiture in hemorrhoids, pruritus, and perineal suturing, and *Dermoplast,* in an aerosol freon propellent spray for fast relief of surface pain, itching, burns, and abrasions. Also for OB-GYN use.

80—Eaton Laboratories, Norwich, N. Y.

A new specific for *Trichomonas vaginalis* is now available for treating trichomonal vaginitis. This is *Tricofuron* (T.M.) Vaginal Suppositories and Powder. *Tricofuron* affords relief of symptoms within a few days, and cures the majority of cases within one menstrual cycle. The latest clinical data on *Furadantin*(R) in treating urinary tract infections and prostatitis will also be available.

17—Encyclopaedia Britannica, Chicago, Ill.

Encyclopaedia Britannica proudly announces the biggest release in nearly 200 years. You are cordially invited to inspect the new 1956 edition of Encyclopaedia Britannica. Year Book, World Atlas, and sample Research Reports will be available for inspection. Take advantage of SPECIAL EXHIBIT OFFER.

64—Endo Products Inc., Chicago, Ill.

Endo will feature the new analgesic *Percodan,* which provides both speed of action and duration of effect with less incidence of side effects. *Hycodan* and *Endotussin* for symptomatic treatment of common colds and cough will also be shown. Latest clinical data on *Tubadil,* skeletal muscle relaxant, will be available.

73—The Evron Company, Chicago, Ill.

The Evron exhibit features *Pentritol Tempules* for the prevention of anginal attack. These controlled disintegration capsules of 30 mg. of pentaerythritol tetranitrate enable you to treat your patient for 12 hours with each Tempule. Experienced representatives will be available to explain the advantages of this superior coronary vasodilator and to answer your questions.

Booth Company and Products

10—H. G. Fischer & Company, Franklin Park, Ill.

Our exhibit will feature the latest models of modern x-ray machines, F.C.C.–approved ultrasonic generators, short wave diathermy units, and low voltage generators, all of highest quality materials and construction. Representatives in attendance will welcome an opportunity to give demonstrations and quote today's low prices.

99—C. B. Fleet Company, Inc., Lynchburg, Va.

During the past 50 years *Phospho–Soda* (Fleet) has been a symbol of elegance in sodium phosphate medication. *Fleet Enema Disposable Unit,* an enema solution of *Phospho–Soda* (Fleet), is a worthy companion product. The single-use unit simplifies and assures satisfying preparation for proctoscopy, and for a routine enema it is a boon to the hospitalized patient.

36—E. Fougera & Company, Inc., New York, N. Y.

E. Fougera & Company, Inc., and Division, Varick Pharmacal Company, Inc., cordially invite physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

59—Geigy Pharmaceuticals, Division of the Geigy Chemical Corp., New York, N. Y.

Medomin, a new kind of barbiturate, will highlight the Geigy exhibit. Indicated for safe, gentle hypnosis and reliable, sustained sedation, *Medomin* is unique in that a 7-member ring is attached to the barbiturate radical. Also featured will be *Butazolidin,* nonhormonal antiarthritic; *Eurax,* antipruritic and scabicide; and *Sterosan,* bacteriostat and fungistat.

1—General Electric Company, X-Ray Department, Milwaukee

We will again be exhibiting in Booth 1. Our representatives who cover your territory will be on hand to greet you. We expect to display our new streamlined Inductotherm, DWB Cardioscribe, and the usual supply items.

28—Gerber Products Company, Fremont, Mich.

When milk is contraindicated as the basic food for infants, Gerber "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

91—Hoffmann-La Roche, Inc., Nutley, N. J.

Gantrisin (acetyl) *Pediatric Suspension,* a raspberry-flavored suspension that is useful for treating systemic and urinary tract infections and as prophylaxis for recurrent attacks of rheumatic fever; *Noludar,* a new, nonbarbiturate sedative-hypnotic which provides effective relief of insomnia and tension states. *Noludar* is so well tolerated that side effects such as nausea, vomiting, and dizziness are rarely, if ever, experienced with therapeutic doses. *Noludar* is available in scored tablets of two strengths, 50 mg. and 200 mg., and in a cordial-flavored elixir, 50 mg. per teaspoonful. *Vi–Penta Drops,* an aqueous, nonalcoholic multivitamin preparation taken as a supplement in preventing and treating multiple vitamin deficiencies in infants and children.

72—Horlicks Corporation, Pharmaceutical Division, Racine

Our exhibit will feature *Nulacin*—a unique milk-antacid tablet formulated to dissolve slowly in the mouth. Thus, the contained antacids are gradually released, providing the ambulatory patient with continuous acid neutralization. Because of this new mode of treatment, *Nulacin* is comparable in efficacy to the continuous intragastric drip method.

Booth Company and Products

84, 100—Hurley X-Ray Company, Milwaukee

Items of the Picker X-Ray line and the Burdick Physical Medicine equipment will be featured at this meeting. Our fieldmen will be present to visit with you and to discuss your needs. Stop by; we will enjoy your fellowship.

4—Kremers–Urban Company, Milwaukee

At our exhibit you will find new information on the ACTH–like antirheumatic, *Salimeph–C,* without side effects. See the new, most potent visceral antispasmodic—*Levsin Sulfate*—and get information on the prevention of anginal attacks through the use of *Nitrol Tablets* and *Nitrol Ointment.* Also on display will be new *Amitrate* for coronary insufficiency.

8, 9—Lakeside Laboratories, Inc., Milwaukee

You are cordially invited to visit our booth, where members of our sales staff will be available to discuss the oral diuretic *Neohydrin, Pediatric Piptal,* and *Tridal.*

88—Langer Laboratories, Inc., Milwaukee

This year we're back again to show
The well-known names whose fame you know
And hope you'll stop a while to view
Our products old and products new.

44—Lederle Laboratories Division, American Cyanamid Company, Pearl River, N. Y.

You are cordially invited to visit our booth, where representatives will provide the latest information and literature available on our line. Featured will be *Achromycin, Incremin, Diamox,* Vitamins, *Pathilon, Varidase,* and many other of our dependable quality products.

41—Eli Lilly and Company, Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

32—J. B. Lippincott Company, Philadelphia, Pa.

We will present for your approval a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

33—Loewi and Company, Milwaukee

The Loewi & Co., Inc., booth will offer investment information on all leading companies. Current financial news will be displayed by use of a Dow Jones news teletype. Members of our organization will be present to answer questions. A private wire to our Milwaukee office will furnish the latest quotations upon request.

67—Lov-e' Brassiere Company, Hollywood, Calif.

We invite you to view our complete line of custom-fitted brassieres, available in a range of 18 models of more than 500 size variations. These Lov-é models have been designed for specific breast conditions and are individually fitted by trained corsetieres in exact accordance with prescription instructions. The Lov-é line is featured in leading department stores and corset shops coast to coast.

3—Maico of Milwaukee, Milwaukee

Maico Hearing Services of Milwaukee and Madison represent the laboratories of the Medical Acoustic Instrument Company, Minneapolis. Maico research and production of fine audiometers and prosthetic aids has contributed much to the science of hearing evaluation and correction of hearing loss throughout the world. Wisconsin distributors will show the electronic stethescope and a full line of hearing aids and hearing test instruments.

Booth Company and Products

69—The S. E. Massengill Company, Bristol, Tenn.

We will exhibit *Salcort*, a judicious combination of salicylates and cortisone for the treatment of arthritic and rheumatoid affections, and *Homagenets*, the homogenized vitamins. A liquid suspension in a solid form, *Homagenets* may be chewed, swallowed, or allowed to dissolve on the tongue. Homogenized vitamins are better absorbed and better utilized, and large vitamin excesses are unnecessary.

118—Mead Johnson & Company, Evansville, Ind.

The new Deca vitamin family for the vital first decade of life will be featured. Included in the new Deca family of vitamin specialties are: *Deca-Vi-Sol*, for dropper dosage, a fruit-flavored solution for infants and toddlers; *Deca-Mulcin*, for teaspoon dosage, a pleasantly flavored liquid for preschool children of 2 to 6 years; and *Deca-Vi-Caps*, small, easily swallowed capsules, for school-agers of 6 to 10 years. All three Deca vitamin specialties supply 10 nutritionally significant vitamins, including A, C, and D, plus 7 important B vitamins.

53—The Medical Protective Company, Fort Wayne, Ind.

Exclusive application to Professional Liability Insurance—distinctive of The Medical Protective Company—assures superior defense and proved protection for the doctor. Policyholders suffer no involuntary loss from their own pockets in the payment of damages. Of all our policyholders, 99.94% have been completely covered under $2,500.

115—Medico-Mart, Inc., Milwaukee

You are cordially invited to visit our booth. Our display will consist of Hamilton equipment; Raytheon Microtherms; Castle, Pelton, and American Sterilizers; Surgical Instruments; and Welch-Allyn Otoscopes and Ophthalmoscopes.

63—The Wm. S. Merrell Company, Cincinnati, Ohio

TACE, the unique non-steroid developed by Merrell, offers a new approach to the treatment of the menopause. *TACE* is temporarily stored in body fat and released over an extended period of time. One course of *TACE* therapy is generally all that is required to ease many patients into the symptom-free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent. Our representatives will answer any questions you have concerning this new and distinctive estrogen as well as discuss other Merrell specialties.

15—Milex-Alpha Products, Evanston, Ill.

Milex representatives will be on hand to demonstrate the new Milex Cancer Detection Program for early diagnosis of cancer of the female organs. Milex Plastic Folding Pessaries with the New Full Support will be displayed as well as Milex Tricho-San Jel Jector Treatment Sets and the Milex Pro-ception Program for the treatment of infertility.

51—Miller Surgical Company, Chicago, Ill.

See the Miller Electro-Surgical Units with Snares, Suction-Coagulation attachments, and other accessories. There will also be on display a complete line of illuminated diagnostic equipment consisting of Otoscopes, Ophthalmoscopes, Eyespud with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum with Smoke Ejector, Gorsch Operating Scopes, and Stainless Steel Proctoscopes with magnification.

55—V. Mueller & Company, Chicago, Ill.

An interesting selection of fine instruments—both standard and special—of particular interest to the general surgeon will be displayed by V. Mueller & Company.

Booth Company and Products

119—John Nichols, Inc., Milwaukee

Gray PhonAudograph remote dictating equipment and individual machines can now be *rented* or *purchased* with *no down payment* required. You will want to see and hear what is new in Audograph. May we suggest you stop at Booth 119 for demonstration and arrange for a trial.

79—The Orthopedic Appliance Company, Inc., Milwaukee

A complete line of surgical, prosthetic, and orthopedic appliances will be on display, as well as custom-made bracing and corsets. The latest approved methods and designs by UCLA and the National Research Council on upper extremity prosthetics will also be featured.

81—Parke, Davis & Company, Detroit, Mich.

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products. Important specialties, such as *Penicillin S-R*, *Benadryl*, *Ambodryl*, *Dilantin Suspension*, Vitamins, *Oxycel*, *Milontin*, *Amphedase*, *Chloromycetin*, *Thrombin Topical*, etc., will be featured.

35—Pet Milk Company, St. Louis, Mo.

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature "Pet" Evaporated Milk can will be given to all visitors.

125—Pfizer Laboratories, Brooklyn, N. Y.

The Pfizer exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy—*Tetracyn S.F.* and *Terramycin S. F.* (Stress Fortified). Also on exhibit will be the complete line of Pfizer antibiotics and *Steraject*, as well as the new specialties, *Bonamine*, *Tyzine*, and *Toclase*, and the complete line of steroid hormones including *Cortril* and the latest corticosteroid, *Stcrane* (brand of predisolone).

37, 38—Physicians and Hospitals Supply Company, Minneapolis, Minn.

Our representatives will be very glad to demonstrate all of the latest equipment including electrocardiophones, ultrasonic units, Ulmer Pharmaceuticals, and many other items of interest. Please stop by and see us.

6—Professional Business Service, La Crosse

The busy physician claims numerous benefits from the assistance of Professional Business Service acting in the capacity of part-time advisors or business managers. For example: (1) better public relations with his patients; (2) improved efficiency for his staff; (3) preservation of his life and usefulness by having help with difficult and confusing business problems. Inquiry invited.

13—Professional Office Buildings, Inc., Madison

We will have placards for your inspection which will show floor plans and pictures of various professional office buildings. Also on display will be a small model of one of our buildings.

25—Purdue Frederick Company, New York, N. Y.

We will feature *Senokot*, new non-bulk, nonirritating constipation corrective, acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex; *Pre-Mens*, the multidimensional premenstrual tension therapy; *Colpotab*, a tested effective Tyrothricin trichomonacide; and *Chlorogiene*, a hygienic douche formulation.

Booth Company and Products

116—R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king-size filter cigarette.

58—A. H. Robins Company, Inc., Richmond, Va.

The Robins exhibit features the Donnatal "family" of antispasmodics, including the original Tablets, Capsules, the versatile Elixir, and the new *Donnatal Extentabs*, which provide all-day or all-night effects on single dosage, while the formula combined with B complex and indicated in the medical management of chronic fatigue states is available as *Donnatal Plus*. Also shown are *Entozyme*, *Pabalate*, *Pabalate-Sodium Free*, and the new *Pabalate-HC* (Pabalate with Hydrocortisone).

123, 124—Roemer-Karrer Company, Milwaukee

The Roemer-Karrer Company invites you to visit our display, where our representatives will be on hand to welcome their friends and show them the recent developments in medical equipment as well as the various standard items.

61—J. B. Roerig and Company, Chicago, Ill.

Information will be available on all the well-known Roerig preparations, with particular emphasis on *Viterra Tastitabs*, the family vitamin; *Stimavite*, specially designed for children who do not eat well; *Bonadoxin*, for the prevention of nausea and vomiting of pregnancy or postoperatively; and *Neobon*, for the adult over 40. Literature and clinical material will be available upon request.

71—Ross (M & R) Laboratories, Columbus, Ohio

Current concepts in infant feeding stress the critical aspects of preventive care. Your Similac representative will be happy to discuss the physiologic role of *Similac Powder* and *Similac Liquid* in providing good growth, sound development, and optimum clinical benefits. Reprints of current pediatric investigations and the latest Ross Research Conference Reports are available.

57—Sandoz Pharmaceuticals, Hanover, N. J.

Featured at our booth will be *Fiorinal*, a new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia; *Cafergot*, available in oral and rectal form for effective control of head pain in migraine and other vascular headaches; and *Bellergal*, valuable as an autonomic inhibitor in a variety of functional ills—the volume of favorable clinical reports is constantly increasing.

62—W. B. Saunders Company, Philadelphia, Pa.

Among the newest of special importance of the Saunders books are *Current Therapy*, '56; Sodeman: *Pathologic Physiology;* Laughlin: *The Neuroses;* Bland: *Fluid Balance;* Hinshaw & Garland: *Diseases of the Chest;* Davis-Christopher: *Textbook of Surgery;* and Diggs: *Hematology.*

11—Schering Corporation, Bloomfield, N. J.

Schering's entire exhibit will be devoted to *Meticorten* and *Meticortelone*, the new corticosteroids for the treatment of rheumatoid arthritis, intractable asthma, and other so-called collagen diseases. Extensive clinical and laboratory data demonstrating certain advantages of these new steroids over cortisone and hydrocortisone will be shown.

12—G. D. Searle & Company, Chicago, Ill.

Featured will be *Mictine*, the new safe, non-mercurial oral diuretic; *Vallestril*, the new synthetic estrogen with extremely low incidence of side reactions; *Banthine* and *Pro-Banthine*, the standards in anticholinergic therapy; and *Dramamine*, for the prevention and treatment of motion sickness and other nauseas. Our representatives will be happy to answer any questions regarding Searle Products of Research.

68—Sharp & Dohme, Division of Merck & Company, Philadelphia, Pa.

The Sharp & Dohme exhibit presents highlights on steroid therapy, featuring *Deltra*, *Hydeltra*, and related adrenal cortical steroid preparations for endocrine disorders, collagen diseases, respiratory allergies, eye diseases, and skin conditions. Expertly trained personnel will be pleased to discuss new dosage forms, new indications, and the latest summaries of advanced clinical reports in this field.

14—Slaten Instrument Manufacturing Company, Milwaukee

We invite you to visit our booth, which will feature instruments and equipment of our own make as well as those of other manufacturers. Several new items manufactured by us will be of special interest to both the surgeon and general practitioner.

5—Smith, Kline & French Laboratories, Philadelphia, Pa.

S.K.F. is glad to introduce its new product, *Thora-Dex*, at this meeting. A combination of the tranquilizer, *Thorazine*, and the analeptic, *Dexedrine Sulfate*, *Thora-Dex* is most useful in the control of symptoms of anxiety and depression which so often occur simultaneously in neuroses and psychoses. Come to the S.K.F. booth—we'll gladly tell you more about *Thora-Dex*.

56—E. R. Squibb & Sons, New York, N. Y.

E. R. Squibb & Sons has long been a leader in the development of new therapeutic agents for prevention and treatment of disease. The results of our research are available on new products or improvements on products already marketed. We will be pleased to present up-to-date information on these advances for your consideration.

60—Swift & Company, Chicago, Ill.

The new improved flavor and texture of Swift's Meats for Babies & Juniors, which are now packed in glass jars, will be the keynote of our exhibit. You are cordially invited to discuss these new developments in the originator brand of all-meat products for infants with our representative. Information and literature on the clinical research which investigated the tolerance, acceptance, and benefits of meat in the infant diet will be available.

7—U. S. Vitamin Corporation, New York, N. Y.

Our exhibit will feature an entirely new, safe vasodilator drug with three unique pharmacologic actions: (1) selectively dilates blood vessels of skeletal muscle; (2) mobilizes depot blood; (3) increases cardiac output. Thus, *Arlidin* (Nylidrin HCl, NNR) is indicated in treating intermittent claudication and a wide range of functional and obliterative peripheral vascular disorders. Professional samples and literature also will be available on our complete line of nutritional and pharmaceutical specialties.

34—The Upjohn Company, Kalamazoo, Mich.

Members of the medical profession are invited to visit the Upjohn booth, where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

24—Warner-Chilcott Laboratories, New York, N. Y.

A visit to the Warner-Chilcott booth will pay dividends, especially in the interests of your cardiovascular patients. The company is featuring two "clinically tested and

Booth — Company and Products

proven agents": one, to help you prevent attacks of angina pectoris; the others, the most potent drug currently available for reduction of blood pressure in hypertensive patients.

2—White Laboratories, Inc., Kenilworth, N. J.

Stimulate appetite—improve muscle tone—speed convalescence through a more efficient utilization of protein. "Correct proportion of amino acids to each other in the diet is more important than total protein intake." White's L-lysine preparations—*Lactofort, Cerofort Tablets*, and *Cerofort Elixir*—raise milk, cereal, and vegetable proteins to high values.

54—Winthrop Laboratories, New York, N. Y.

Our exhibit will feature *Alevaire*, the nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neonatal asphyxia.

Booth — Company and Products

95, 96—Wisconsin Physicians Service, Madison

The Blue Shield Plan of the State Medical Society of Wisconsin invites all physicians to stop for a moment, ask questions about Blue Shield coverage and claims, become more familiar with Blue Shield, or just "set a spell." A lounge and coffee will be provided.

22—Wyeth Laboratories, Philadelphia, Pa.

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WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Hotel Schroeder, Milwaukee, Sunday, April 29, 1956

Registration—1:30 P.M., Foyer, Fifth Floor

Scientific Program—2:00 P.M., East Room, Fifth Floor

SCIENTIFIC PROGRAM

1. "Recent Advances in the Management of Asthma"
   G. A. Koelsche, M. D., Mayo Clinic, Rochester, Minnesota
2. "Pulmonary Manifestations of Collagen Diseases"
   Joseph F. Kuzma, M. D., Milwaukee, Wisconsin
3. "Atrial Fibrillation—Reversion to Sinus Rhythm"
   Ray W. Kissane, M. D., Columbus, Ohio
4. "The Significance of Isolated Nodular Lesions in the Chest X-ray"
   Edwin R. Levine, M. D., Chicago, Illinois
5. "The Treatment of Congestive Heart Failure"
   John F. Briggs, M. D., St. Paul, Minnesota
6. Panel Discussion of Questions from the Audience—
   Moderator: Mischa J. Lustok, M. D., Milwaukee, Wisconsin
   Participants: G. A. Koelsche, M. D., Joseph F. Kuzma, M. D., Ray W. Kissane, M. D., Edwin R. Levine, M. D., John F. Briggs, M. D.

NOTICE OF MEETING OF S.M.S. CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION, INC.

The first meeting of the trustees of the S.M.S. Charitable, Educational and Scientific Foundation, Inc., will be held Tuesday noon, May 1, at the Schroeder Hotel. A buffet luncheon will be served to all trustees at the Pere Marquette Room.

This is a most important session of the trustees as it will relate to the specific projects of the organization to be authorized and undertaken during the coming years. Plans for financing the Foundation will be discussed, along with some of the special problems presented in the administration of various contributions.

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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Congenital Bilateral Bony Atresia of the Posterior Nares

By SIDNEY K. WYNN, M. D.,* and JAMES P. CONWAY, M. D.**
Milwaukee

ATRESIA of the posterior nares is a rare congenital anomaly. It may be unilateral or bilateral, complete or incomplete. The obstruction may be membranous, osseous, or mixed. Most such obstructions are the osseous type. Richardson, as long ago as 1913, was of the opinion this congenital deformity was responsible for no small proportion of cases diagnosed as asphyxia neonatorum.

Two patients with this condition, born within a week of each other at St. Mary's Hospital, Milwaukee, were treated recently at Milwaukee Children's Hospital. Both had the typical symptoms of complete bilateral nasal obstruction with profuse, thick, tenacious glairy mucus in the nasal cavity causing dyspnea and cyanosis, especially when they tried to nurse. During the intervals between the times they were having difficulty breathing, they appeared as normal infants except for the condition found on intranasal examination. Glairy mucus that had the appearance of either a white tumor or polypoid tissue was seen in the posterior nasal cavities. When the thick mucus was entirely removed, the red membrane on the nasal side of the posterior choanae was seen.

X-ray examination of the two babies at St. Mary's Hospital, before transfer to Children's Hospital, with Lipiodol injected into the anterior nostrils by means of catheter revealed the complete bilateral block of the posterior choanae (fig. 1, upper and lower left).

Surgery was delayed approximately one month. The procedure was carried out as follows: Mirror examination with retraction of the palate located the complete blockage posteriorly in the nasopharynx. By means of a probe it was determined that there was a membranous and bony blockage of both posterior choanae with no air passage possible. Suction was used, and glistening thick mucus was aspirated from both sides of the nose. By means of a bent Kirschner wire, an initial hole was made through the posterior choanae bilaterally. Through this hole a probe of metal was entered. This probe had an eye on its end. The probe was brought through the nose above the palate and out of the mouth. A No. 8 catheter was then strung through the eye of the probe, and this was forced through the posterior choanal opening, so that the catheter ran from the external opening through the nose, above the palate, and out of the mouth. By means of a seesaw action, it was possible to make the opening larger with doubled catheter bilaterally. Then a portex endotracheal tube, 5 mm. in diameter, was strung over the No. 8 catheter, which was cut through and used singly. This endotracheal tube was sutured to the catheter in order to give no chance of slippage. It was possible to run the endotracheal tube through on the left side by this means. On the right side the opening was tighter and it

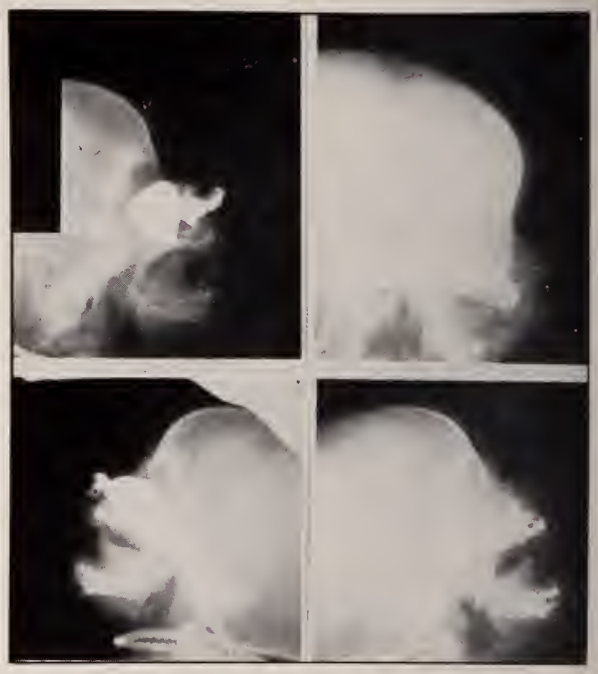


Fig. 1—Upper left—Preoperative x-ray with Lipiodol. Baby B. Lower left—Preoperative x-ray with Lipiodol. Baby W. Upper right—Postoperative x-rays revealing nasal breathing tubes in place. Baby B. Lower right—Postoperative x-rays revealing nasal breathing tubes in place. Baby W.

* Plastic Surgical Service, Milwaukee Children's Hospital — Associated with Marquette University School of Medicine and School of Dentistry. Assistant Professor, Department of Oral Rehabilitation.

** Pediatric Service, Milwaukee Children's Hospital, and Assistant Professor of Pediatrics, Marquette University School of Medicine.

Fig. 2—Demonstration on skull of use of polyethylene dilator in nose.

was impossible to run it over the catheter. In view of this fact, the probe was readmitted, and the endotracheal tube was run over the probe and tied through the eye of the probe in order to stabilize the tube. The probe was then forcibly extracted through the mouth with the overlying endotracheal tube, and in this fashion it was possible to open up the choanae. The tubes were then cut flush underneath the palate, and a mattress suture was used through the endotracheal tube on each side of the nose just behind the columella in order to stabilize the tube in this position. The endotracheal tubes were then cut just outside of the height of the columella.

The patients were sent to their room under oxygen for the first 24 hours until they became well stabilized. After this time they were able to take mouth feedings much better. The portex tubes were left in position for 12 days. X-rays showed the tubes running through the nasal cavities re-establishing the airway (fig. 1, upper and lower right).

The babies were released from the hospital two weeks following surgery and reported to the office at one-week intervals thereafter. It was necessary to reopen the nose each time with a metal probe as some stenosis of the openings had taken place, causing difficulty with breathing. One month after their discharge a polyethylene dilator was devised which was less traumatic and much easier to handle (fig. 2). This dilator was run from the anterior nares through the nasal cavity out the posterior nares until it could be visualized in the posterior pharynx. Due to the fact that it is resilient and tapers with the proper curve, one does not have to fear that he is going to perforate the wrong structure. Dilatation was necessary once weekly for a period of two and one-half months until no further stenosis took place and nose breathing was well established.

One of the infants was readmitted to the hospital two months after surgery in a shocklike state, gray in color, and with the history of a recent cyanotic spell at home. A blood count revealed 6 gm. of hemoglobin. Transfusions were given. The baby began having Cheyne-Stokes respiration with apnea periods as long as 60 seconds and convulsive seizures. Diagnosis was made of purulent staphylococcic meningitis by spinal tap three days after admission. This baby eventually recovered under antibiotic therapy, and no further dilatation was found necessary.

When these babies (fig. 3) are older and able to undergo more surgery, then we believe it would be possible to do an actual surgical removal of a portion of the bony atresia if this is necessary at that time.

Comment

This condition is extremely rare. Anderson in 1937 found records of only 6 cases of congenital occlusion of the choanae in the previous 30 years at the Mayo Clinic. Only one of these was bilateral—an incomplete one in an 11-year-old child.

The most recent report is by Beinfield. He describes congenital bilateral bony atresia of the posterior nares in a one-month premature infant who survived. He erroneously claims this as the first article appearing in the literature on this condition.

The syndrome is similar to the one described for enlarged thymus gland. It has been diagnosed as such in the past. When

Fig. 3—Postoperative photos taken in office on Babies B & W at one of dilatation visits. Note similarity of babies' appearance. There was no relationship between these babies.

the occlusion is partial, although the opening in the posterior choanae is small, it may escape recognition until the patient has an examination of the nasopharynx with a mirror.

Paradoxical expiratory ballooning of the hypopharynx can be demonstrated by x-ray examination according to Whitehouse and Holt, who made the observation in siblings with bilateral choanal atresia. This is in direct contrast to what happens in the normal infant in early childhood, described by Pancoast as follows: "During inspiratory phase the pharynx is often filled with air and the post-pharyngeal space is comparatively narrow. During expiration the space may be much wider when the pharyngeal space is completely or partially collapsed."

Hay described the presence of air in the pharynx in the inspiratory phase and demonstrated with excellent illustrations the relative distention of the hypopharynx during inspiration in contrast to collapse during expiration and, as observed by Whitehouse, the reversal of these normal findings in complete bilateral atresia. These findings are of considerable aid in diagnosis of cases of this type.

Early surgery is indicated for these babies since the bone becomes more sclerotic as time progresses. This is especially true if there is an inflammatory condition within the nostrils. The normal mucus stagnates in the affected nasal cavity, creates a pathologic condition in the lining membrane of the nose, and causes hypertrophy of the adjacent conchae. The mucosa then becomes pale and waterlogged. This was present on the right side in the first of our patients.

Many methods have been used for removal of the obstruction—the trocar, rasp, nasal punch, bone gouges, electric burrs, and other biting forceps. In the adult, bony atresia is managed by submucus resection of the entire osseous septum extending into the choanae involved. This has been reported only for unilateral obstructions as bilateral posterior choanae obstruction has not been described in adults.

We feel now, with the experience gained from our patients, there is no reason why surgery cannot be performed very soon after birth.

Summary

A report of 2 patients with bilateral posterior choanal atresia treated successfully has been given. Probably many children have died shortly after birth from this condition which went undiagnosed. The patency of the choanae should be determined in all newborns, especially in those with any difficulty with breathing. The examination can easily be accomplished with the use of a No. 8 rubber catheter introduced through the floor of the nose until it can be seen in the pharynx. Lipiodol in the nasal cavity is a valuable diagnostic aid. Fluoroscopic examination is indicated in patients with choanal atresia since the degree of blocking of the respiratory passage can be determined by the amount of expiratory ballooning of the hypopharynx. Surgical procedure should be as simple as possible with the amount of tissue removed kept at a minimum. The use of a polyethylene dilator as described was of considerable help in the postoperative management of our patients.

(S. K. W.) 759 North Milwaukee Street.

REFERENCES

1. Richardson, C. W.: Congenital osseous obstruction of postnasal orifices, Ann. Otol., Rhin., & Laryng. 22:488–491 (June) 1913, as quoted in Thomson, St. Clair, Diseases of the Nose and Throat, ed. 2, New York, D. Appleton & Company, 1920.
2. Anderson, C. M.: Congenital occlusion of choana, J. A. M. A. 109:1788–1792 (Nov. 27) 1937.
3. Beinfield, Henry H.: Congenital bilateral bony atresia of posterior nares in one-month premature infant who survived, J. Pediat. 45: 679–687 (Dec.) 1954.

(References continued on page 454)

Gamma Globulin in Treatment of Epidemic Infectious Hepatitis

By FRED J. ANSFIELD, M. D.
Glidden

NUMEROUS articles have appeared in the past several years concerning the use of gamma globulin prophylactically in the prevention of infectious hepatitis in exposed individuals. Drake and Ming[1] made a careful comparison of two dosage levels in the use of gamma globulin in exposed inmates in a closed institution. Stokes[2] delved into the length of protection afforded by immune serum globulin. But nowhere in the literature is there any reference to the use of gamma globulin as a direct treatment for infectious hepatitis in a patient actively ill with this disease and in the acute and icteric phase.

In 1944 and 1945 in Leyte and Luzon, I treated with rather indifferent results approximately sixty soldiers with infectious hepatitis who chose to remain in combat in preference to evacuation. In 1948 in Glidden, during a severe epidemic of infectious hepatitis, I treated approximately fifty patients through long protracted sieges of this illness ranging from several weeks to several months. In spite of bed rest and restriction of fats, many patients remained ill for so long a period that it became a serious socio-economic situation when the head of a family was stricken. Many patients appeared to improve, only to have a relapse and sometimes even a second relapse. Waisman[3] points out that the duration of jaundice is about four to eight weeks and recommends bed rest for at least two or three months.

Following that 1948 epidemic, there were no cases of viral hepatitis in this community until eight months ago, when a sawmill worker reported to me with symptoms of epigastric pain, nausea, diarrhea, anorexia, and malaise. There were findings of fever, hepatomegaly, tender liver, icteric tint to the sclera, and a dark orange urine.

The last two findings were present in 100% of a total of 42 cases that I treated in Glidden and Butternut during this current epidemic. In this series there were few instances of palpable enlarged liver, though most patients had pain and tenderness in the liver area. No liver function studies were made. The diagnosis was made on the basis of at least several of the symptoms elicited above plus the icteric tint to the sclera and the characteristic dark orange urine. There may have been some cases of anicteric hepatitis during this epidemic; but without the availability of a laboratory here to perform liver function tests, they were not recognized. At any rate, if some in our community had anicteric hepatitis, they were not disabled and recovered spontaneously.

In 1953, Dr. Frank F. Gollin of La Farge, Wisconsin, informed me that gamma globulin was valuable not only for prophylactic use in exposed individuals, but also in the actual treatment of the disease. On the basis of this information I proceeded to treat the sawmill employee with one injection of 6 cc. gamma globulin intramuscularly. He responded so remarkably that he returned to work in five days. Accordingly, all 42 patients with clinical jaundice were given 6 cc. gamma globulin intramuscularly at the first visit and were also given instructions as to bed rest and diet. Thirty-nine of the patients were well within seven days, and most of them were out of bed sooner, on full duty, and had resumed their normal food intake. Two children had little to no response to the one injection, and they were given a second injection one week later, with rapid disappearance of all symptoms and signs of hepatitis. One other patient received a second injection of 6 cc. gamma globulin. He was a 68-year-old man with bronchiectasis, arteriosclerotic heart disease, and probable amyloidosis. Three days after his initial injection, he was considerably improved; but it was felt a second injection would insure full and rapid recovery without sequelae. The entire series recovered promptly without sequelae.

Early in the epidemic, when one member of a family developed hepatitis, the rest of the family was urged to have a prophylactic injection of gamma globulin. Later in the

epidemic, having observed the excellent response to gamma globulin in the treatment of the patient ill with hepatitis, I no longer recommended prophylactic use of gamma globulin, even in family contacts. The family was cautioned about the spread by personal contact and apparently by the fecal-oral route.[1] Frequently no other member of the family contracts the disease and since the treatment of this admittedly serious disease is so rapidly effective and simple, I do not feel prophylactic use of gamma globulin is warranted. This plan of using gamma globulin only in the treatment of the active cases of hepatitis has reduced appreciably the amount of gamma globulin used during the second half of the epidemic as compared to the amount used during the first half. This saving might be important if it were to develop that gamma globulin might be effective in the active treatment of other virus diseases such as poliomyelitis, measles, and virus pneumonia. We have for some years effectively used gamma globulin to modify or prevent measles in exposed children. More recently we have used it with some success in children theoretically exposed to poliomyelitis. By analogy, might not gamma globulin in high doses be effective in the actual treatment of these viral diseases even as it is in hepatitis?

Summary

A series of 42 cases of infectious hepatitis were treated during the past eight months with 6 cc. gamma globulin injected intramuscularly as soon as the diagnosis was made clinically. Thirty-nine responded very rapidly and effectively with an apparently complete cure in seven days. Two children required a repeat injection one week after the first.

The question is raised: Would not gamma globulin similarly be effective in the active treatment of other viral infections?

REFERENCES

1. Drake, Miles E., and Ming, C.: Gamma globulin in epidemic hepatitis; comparative value of two dosage levels, apparently near minimal effective level, J.A.M.A. 155:1302–1305 (Aug. 7) 1954.
2. Stokes, J., Jr., and others: Infectious hapatitis; length of protection by immune serum globulin (gamma globulin) during epidemics, J.A.M.A. 147:714–719 (Oct. 20) 1951.
3. Waisman, Harry A.: Infectious hepatitis, Health 13:22–23 (July, Aug., Sept.) 1955.

"BIOCHEMISTRY AND MYCOLOGY" COURSE OFFERED BY MARQUETTE UNIVERSITY

A continuation course in "Biochemistry and Mycology" for medical technologists will be offered on May 19 and 20 through the postgraduate programs of Marquette University's School of Medicine.

The course has been designed to emphasize the technical and clinical aspects of biochemistry and mycology of use to the medical technologist.

The program will be under the direction of Joseph F. Kuzma, M. D., head of the pathology department at Marquette, and Miss Marianne Schaaf, director of medical technology.

Visiting faculty will include Opal E. Hepler, Ph.D., M. D., Northwestern University School of Medicine; Samuel Natelson, Ph.D., chairman of the biochemistry department, Rockford Memorial Hospital; and Libero Ajello, Ph.D., U. S. Public Health communicable disease center, Chamblee, Georgia.

Tuberculin Tests: Their Importance in a State Program of Tuberculosis Control*

By HELEN A. DICKIE, M. D.**
Madison

Value of Tests

THERE is no doubt that the tuberculin test is one of the most useful tests in medicine. It is the most reliable method of determining whether any person has been infected by the tubercle bacillus. When tuberculin tests were first utilized, the incidence of tuberculous infection was so high that almost universal tuberculin sensitivity was found in the adult population. It was not until rather large groups, especially in the American colleges and universities, were tested that it was shown that at least in the Midwest the majority of the college students had escaped infection.

With these and many other studies it was well established that tuberculin sensitivity was closely correlated with the incidence of tuberculosis in the community and the density of the population. The tuberculin sensitivity level of the lifetime residents of any community will reflect the effectiveness of control of tuberculosis. Obviously, if the recent changes are to be checked the young age groups will be the ones that will reflect this trend. The other method of securing the idea of effective control in the community is by repeating tuberculin tests yearly so the annual risk of infection in a group may be then determined. Frequent repetitions of the tuberculin test may be of great importance in localizing the source of the infection. The incidence of tuberculin sensitivity in any larger group may be very helpful in determining whether there is a great enough deviation from the usual in the area to suggest that some unusual incidence of tuberculous infection has occurred. Frequently, this will indicate the increased risk so that measures to find and eliminate the source of these infections may be undertaken.

In the past few years the importance of regular and repeated tuberculin tests has received a new stimulus. There has been such improvement in the drug therapy of tuberculosis that it is a natural development to consider drug therapy of the individual as soon as tuberculous infection is recognized. The demonstration of a reaction to tuberculin in any individual who previously showed no reaction to this antigen is the first and frequently the only proof of the infection at the moment. On this basis many workers believe that there is justification of antituberculous treatment with isoniazid alone for nine to twelve months without awaiting any development of overt disease.

From numerous studies of student nurses and medical students it has been shown that 10 to 15% of the recently infected individuals will develop roentgen or clinical evidence of tuberculosis. The first two years following this first infection is the most dangerous period. While it is true that some of these individuals may have only a small infiltrate on their chest x-ray which will gradually heal without any great difficulty, the majority of this group will develop progressive disease, sometimes with alarming rapidity.

Repeated tuberculin tests are of considerable value not only from the standpoint of epidemiology, but also from that of the individual patient's protection. Certainly, it is very necessary to follow the recently infected person very closely. More recently, the possibility of treating such persons with isoniazid only has been considered and tried on a small scale. Certainly, this is a very potent antituberculous drug which will control infection quite satisfactorily if there has not been gross damage to the lung and cavity formation. The drug is cheap, can be taken by mouth, and has few serious toxic effects. The major problem in trying to test the effectiveness of early treatment of recently infected persons is to find these persons. Tuberculin tests done regularly with adequate

* Prepared for and endorsed by the Division on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin, February 1956.

** Professor of Medicine, University of Wisconsin Medical School.

record so that the information can be obtained is the only possible method. Obviously, unless one is dealing with very young children, it is impossible to know how long an individual has had a positive tuberculin skin reaction unless there is an adequate record of a previous tuberculin reaction or lack of reaction to the tuberculin.

The tuberculin test is of great aid to the physician in the recognition of disease. In a person who has a pleural effusion, pericarditis, pulmonary disease, arthritis, or many other illnesses, a positive tuberculin test may be the first clue that the tubercle bacillus is the probable cause. The significance of a positive tuberculin reaction is greatly enhanced if it can be demonstrated that this reaction to tuberculin is a recent change. Contrariwise, failure of the patient to react to adequately performed tuberculin tests is almost a certain proof that the disease process is not due to the tubercle bacillus.

There seems no reason at the present time not to employ repeated tuberculin testing programs in schools and in groups of individuals whose tuberculin sensitivity is not so high that tuberculin testing need not be repeated because nearly all of the group would again react. In the State of Wisconsin it is highly improbable that such a situation does exist, except possibly in a highly industrialized area and there probably among only the older males.

Technique of Administering Tests

The tuberculin test can be done very easily. However, there is one major difficulty in utilizing it and that is that the reaction is a delayed one and the test must be read at a later date, preferably at 48 to 72 hours for the usual intradermal test.

At the present time the intradermal test which utilizes the technique of the intracutaneous injection of old tuberculin or a purified protein derivative (P.P.D.) is the preferable one. It is cheaper, more easily read, and can't be tampered with. The usual complaint that it is an intradermal test, which requires an injection, is not very valid in view of the widespread use of other tests and immunizations which have been accepted. A good education program should convince the parents that the intradermal tuberculin test is the best one. The so-called "patch" test utilizes the tuberculin solution dried in the gauze which is applied to the defatted skin anywhere on the body. If it is placed on the forearm, it very likely has to be tampered with. If it is placed in the intrascapular area, this creates considerable difficulty in both placing and reading the test. The patch test should remain in place for 48 hours, then be removed, and the test read 48 hours after that. The obvious defect is that it is impossible to be sure that the tuberculin has been in contact long enough to produce the characteristic reaction.

The dose of P.P.D. or old tuberculin is of considerable importance. If too strong a tuberculin solution is utilized, two serious drawbacks occur. The first problem is that severe local reactions may be produced in a few highly sensitive people. This is obviously undesirable in the public acceptance even though it will have no serious effect on the person. The other difficulty, which is much more significant, is that if too strong an antigen is used, many nonspecific reactions may occur. If too small a dose is utilized, the less sensitive of the infected group will be missed.

In large testing programs the use of .0001 mg. P.P.D. or 0.1 mg. O.T. per .1 cc. of the solution is the usual recommendation. These doses are adequate to discover the infected individual and yet avoid the small reactions which do not appear to be correlated to tuberculous infection, but are possibly a cross sensitization with an acid-fast bacillus which is not the pathogenic human or bovine tubercle bacillus. The incidence of significant tuberculous disease found in the people who failed to respond to this intermediate strength, but responded to 1.0 mg. O.T. or .005 mg. P.P.D. has been negligible in large study groups.

The actual technique of the tuberculin test is important. The tuberculin solution must be fresh. Any diluted solution which has been kept for more than a few weeks is frequently much less potent an antigen than when it was first diluted. The tuberculin solution must be injected intracutaneously and not subcutaneously. If given subcutaneously the redness or induration is very much decreased or even absent. The intracutaneous injection will always produce a clear-cut wheal formation. If this is not evident with the start of the injection, the needle must be withdrawn and replaced so that the wheal formation occurs. This intradermal tech-

nique is very simple and can be done very rapidly after a little practice. A sharp needle is essential.

Reading and Interpreting Tests

The technique of reading tuberculin tests is readily mastered. The redness is not as important as the induration from the edema. The forearm should be relaxed, and the examiner should palpate the area as well as inspect it in a good light. The induration is usually greater than the area of redness, although occasionally only redness occurs. The test that reveals no induration associated with a small pink discoloration is not a significant reaction. The tests should be recorded with a measurement of the area of induration, measured in the greatest longitudinal and transverse diameters. Usually this is recorded in millimeters or centimeters; for example, 15 mm. x 30 mm. If vesication or ulceration has occurred, this should be indicated. The reasons for such records of the types of reactions are several. It is much easier to check on the potency of the tuberculin solution. For example, if there are almost no reactions greater than 10 x 20 mm., it is doubtful that the tuberculin utilized was as potent as desired. If a large number of reactions occur which are very markedly positive (70 x 100 mm. reactions, for example) with a fair number showing vesication at their centers, it would suggest that the tuberculin antigen was stronger than the above recommendations and that therefore some of the lesser reactions may be of the nonspecific variety previously mentioned.

If tuberculin retesting of a group is to be carried out, the individuals with the most marked reactions can be eliminated as they may well object to another test while retesting of the individuals with smaller reaction; for example, 10 x 10 mm. to 20 x 20 mm. may be desirable.

In tuberculin testing it is not possible to conclude that the individual who has a severe reaction is any more likely to have actual tuberculous disease than the one with a less marked reaction. The only conclusion that is justified is that a strongly positive test is more likely a recent tuberculous infection as the sensitivity does seem to decrease gradually. Otherwise, the variation is probably a reflection of the ability of an individual to produce a delayed bacterial sensitivity. In a testing program of well individuals the remote possibility of tuberculin sensitivity loss from acute exanthemata and acute serious tuberculosis and other chronic illness is not a problem.

As in any biological test, there will be reactions that are borderline. If these are found, it is advisable to have chest x-rays done and to repeat the tuberculin test subsequently rather than categorically stating that the reaction certainly is evidence of tuberculous infection. If the test has been done properly and the proper tuberculin solution utilized, this type of reaction will be quite unusual. If the induration is less than 10 mm. x 10 mm., it is of doubtful significance and should not be recorded as a positive reaction, but listed as a doubtful reaction. Retesting should be done on the next survey.

In spite of the theoretical hazard of serum hepatitis following an intracutaneous injection, we have continued to utilize the method of flaming the needle between injections. From thousands of tuberculin tests done by this method we have seen no evidence of hepatitis in the student groups so tested. From a practical standpoint, to insist on a separate needle and tuberculin syringe for each injection with the requirement of autoclaving these instruments prior to reusing them would make an intracutaneous testing program of large numbers almost impossible because of the cost of equipment. An alcohol sponge to clean the area of intracutaneous injection is usually utilized. If the individual giving the tuberculin tests has no other responsibility such as explanation and recording at the same time, tests may be given at a very rapid rate. From the standpoint of the individuals tested and the school or industrial personnel, this speed is highly desirable. In addition, it is much easier to obtain the needed additional help, both clerical and medical, if the testing program is completed with dispatch. Obviously, the educational program must be completed before the actual testing. The individual to be tested may be somewhat fearful and in no mood to have a long discussion of the tuberculin test. If the line of individuals to be tested is kept moving, the incidence of syncope is almost completely eliminated. During the reading of the tests more time can be allowed because the fear of the needle is not a factor and accuracy of the recording of the readings is highly essential.

These details are trivial, but the realization of them is essential to the planning of a tuberculin testing program which doesn't delay the normal activities of the group to be tested. The actual plan to be used will depend a great deal on the numbers to be tested and the physical aspects of the area utilized. A satisfactory plan where the whole program is carried out with dispatch is essential to the acceptance of any such tuberculin testing program.

Work Following Test Reading

Once the tuberculin testing has been accomplished, the real work of the program begins. The tuberculin positive individuals should have chest roentgenograms. Whether these be the photofluorograms or conventional roentgenograms is primarily a matter of availability, as either would be acceptable. In a young age group the 14 x 17 standard chest roentgenograms might be preferable because of the difficulty in recognizing minimal lymphadenopathy on the photofluorograms. A recent converter or a young individual should be the object of a concerted effort to find the source of infection. Obviously, the home contacts and school contacts should be surveyed. If not fruitful, the search should be continued to social contacts, etc., as far as possible. The family will frequently be very interested and helpful if it is made to understand the problem. Of course, this is a time-consuming task and will be easier when more surveys have been conducted and the educational programs more frequently given.

The recently infected individual should be referred to his own physician for physical evaluation and consideration of prophylactic therapy unless there has been some other arrangement made by the school physicians in cooperation with the family physician.

The school surveys should give an opportunity for education and a good chance to check the effectiveness of tuberculosis control in any community. With many of the schools reporting no more than two to four per cent of the grade school children infected, the surveys will not be a great source of new case finding among those tested. The largest group of newly discovered patients will be among the grade school or high school students' contacts. However, a properly organized tuberculin testing program is not expensive; and on the annual retesting programs, the number of newly infected individuals will be small. If any large number of converters are found, it will be a clear warning that some source of tuberculosis exists and must be discovered. At times the difficulty in locating the source of the tubercle bacilli may be great and may require the efforts of the public health authorities and all the medical group in the community. However, such problems are not unique to tuberculosis case-finding programs, but are shared in many other infectious diseases where the infected individual who is the source of the causative agent is not ill. The typhoid carrier is an excellent example of such a problem.

Summary

In summary, the tuberculin test is an accurate and very valuable test. Information gained from such testing can not be obtained in any other manner. Tuberculin testing can be done without too great an expenditure of time and money, especially when frequent tuberculin surveys are done. The major expense will be in the necessary follow-up of the contacts of the tuberculin reactor. After surveys have been repeated for a few years, the number of new reactors will not be great, but should give a very important lead as to the source of recent infection.

Although tuberculosis is causing fewer deaths, the incidence of new cases is still not markedly decreased. In addition to finding the active case, we must consider the possibility of recognizing tuberculous infection as soon as possible to protect the infected person and to break the continued exposure of the population. The widespread use of tuberculin testing programs with adequate methods to isolate the source of infection of the tuberculin reactor will aid materially in control of tuberculosis. Many of the reasons for the development of tuberculous disease in those infected is not understood at the present time. Before tuberculosis can be entirely eliminated, it will probably be necessary to recognize these unknown factors in the wide variation of resistance in individuals. In the meantime, it is mandatory that we continue to utilize the case-finding methods at hand. Although they have some deficiencies, they are very effective and have proved to be economically and medically feasible.

1300 University Avenue.

Participation of Physicians in Private Practice in Basic Tuberculosis Control Procedures*

A. Prevention

1. Phases of program in which physicians can participate in a professional capacity.

a. It is the responsibility of all physicians not only to inform their own patients and their families about the dangers of tuberculosis, its mode of spread and methods of control, but also to assist in preparing the disseminating informational material to the public in cooperation with the health department, tuberculosis associations, and other agencies interested in control and treatment of tuberculosis.

b. Early casefinding and diagnosis:

(1) The doctor's office is a productive site for casefinding. The physician should consider the possibility of tuberculosis in every patient and examine as many as possible by roentgenologic study, especially those with any suspicious signs or symptoms or with history of exposure to tuberculosis; x-ray, tuberculin tests and bacteriological examination should be used as freely as possible.

(2) Physicians should examine all the contacts of their tuberculous patients to find the source of the disease and to detect its spread to others; or should make sure that they are examined by public health department or other clinics. Tuberculin tests and x-ray films should be used.

(3) All physicians should encourage their hospitals to establish a program of routine hospital admission x-rays; if such a program is in effect, to promote its fullest use. As far as admission and periodic chest x-ray films in mental and other institutions are concerned, physicians can influence the responsible operating agencies to institute such programs.

(4) Those physicians who sit on policy-making committees should direct surveys to high prevalence areas.

(5) Private physicians should welcome and support community x-ray surveys; they should participate in them as policy makers; each physician should make certain that suspects screened out by the survey are examined carefully using all the appropriate diagnostic tools; he should sit in on film reading sessions.

(6) As consultants or board members for mental and penal institutions or as staff physicians, should promote routine and periodic chest x-raying in such institutions, as well as routine x-raying in jails.

(7) Physicians should support and use laboratory services as needed and especially in doubtful tuberculosis cases. Accepted laboratory techniques, particularly culture and guinea pig inoculation examinations, should be used since one should not rely on direct smears.

c. It is the duty of all physicians to do everything possible to hospitalize every open active case of tuberculosis. If beds are not available, patients should be adequately isolated and treated at home. It is also the physician's responsibility to see that the patient remains under treatment for a period of time sufficient to reduce the possibility of relapse to a minimum.

d. BCG vaccination of physicians, medical students, nurses, laboratory workers, contacts and others in the more vulnerable groups, who as non-reactors are exposed to tubercle bacilli, should be left to the discretion of the individual physician in the individual case.

2. Phases of the program in which physicians can actively cooperate with others in community projects.

a. Private physicians should refer patients and families to health departments and other health agencies for bedside nursing care, assistance in isolation practices, epidemiologic investigations and family education.

b. The private physician should refer tuberculous patients and their families to social services and public assistance agencies when necessary.

c. Physicians, as citizens, can actively participate in community projects aimed at slum

* Report of the Council on Public Health, American College of Chest Physicians. Reprinted from *Diseases of the Chest*, November, 1955 (Volume XXVIII, No. 5).

clearance, low cost housing projects and other movements aimed at general betterment of the community.

d. The practicing physician should emphasize the importance of pasteurization of milk and milk products, and should support the tuberculin testing program for eradication of tuberculous cattle.

B. Treatment and Follow-up

1. Private physicians have always played and will continue to play a prominent role in the treatment of tuberculosis. While government sanatoria care for the majority of hospitalized tuberculous, many chest physicians, internists, and other specialists are on consultant staffs and play a dominant role in setting treatment policies.

2. In the absence of sanatorium or hospital beds, medical care of tuberculous patients at home is largely in the hands of private physicians. Organized home care programs are operating in many communities in which private physicians should actively participate; they should make certain that patients receive necessary nursing and other services to aid in carrying out medical recommendations.

3. The new drugs have increased the number of tuberculous patients who are eligible for post-sanatorium ambulatory treatment. A large number of these are under the supervision of either private physicians or public clinics.

4. Physicians should perform and stimulate regular follow-up examination of tuberculous patients in the doctor's office or chest clinics. Physicians in private practice often serve part-time in tuberculosis or chest clinics, and all physicians should encourage good clinic service. Private physicians should welcome the help of public health nurses with patients' families and contacts to keep them under medical supervision and increase their understanding of the disease and its spread. In some communities medical social workers are available and can visit patients with social problems. Occasionally voluntary associations employ occupational therapists who can be of assistance to patients in their homes.

5. Ideally, no diagnosed case of tuberculosis should ever be dropped from periodic examination. However, after tuberculosis patients have been inactive for two years close supervision can be relaxed. Physicians should, nevertheless, advise their patients with inactive disease to have an annual examination including an x-ray film.

C. Reporting

1. Physicians should routinely and promptly make out morbidity cards on cases of tuberculosis which come to their attention. If there is any doubt about a previous report being made, the physician should make one out anyhow to assure the completeness of registration and epidemiological follow-up. Death certificates should not only indicate tuberculosis as an immediate or ultimate cause of death, but also as an accompanying condition when present.

2. Private physicians should provide health departments with information about the current status of tuberculosis patients under their care so that continued knowledge and supervision of all cases of tuberculosis in the community is assured.

D. Provision to the Patient of Indicated Ancillary Services

1. It is the responsibility of the private physician to assess the patient's capacity for work in terms of residual disease in the lungs and/or other organs and determine the amount and types of activity permissible for the individual. He must make decisions as to whether or not the patient can return to his former occupation or whether he should return to one requiring less physical exertion. In this decision as in those relating to diagnosis and treatment he can to advantage avail himself of specialist consultation.

2. When it is evident that the patient is in need of vocational training to equip him to enter a new occupation, the physician should be aware of the facilities available for such training. He can call upon the services of the vocational counselor of the Division of Vocational Rehabilitation in his state or territory to assist him.

THE MEDICAL FORUM

WAGES CITED AS BIG ITEM IN RISING HOSPITAL COSTS

Milwaukee—The costs of hospital care can be expected to "increase about 5 per cent annually for many years," according to Ray E. Brown, president of the American Hospital Association. He spoke at the annual meeting of the Wisconsin Hospital Association in Milwaukee, March 15.

He said the average cost per patient day for general hospital care in the United States has risen from $9.39 in 1946 to $21.76 in 1954, an increase of 132 per cent. *At the same time, the consumer price index went up only 37.6 per cent.*

PAY ROLL UP 165%

The main factor in the increase, according to Brown, was the increase in wages. He pointed out that 64 per cent of all hospital costs are in the pay roll and that pay roll costs per patient day had risen at the rate of 165 per cent in the period from 1946 to 1954.

Brown was fearful of the insistence of nurses on lengthening the period of their pre-professional and professional training. He said the inevitable result is a double burden to hospital costs.

TIME LAG, TOO

"It not only increases the salary requirements of the profession when she or he is finally ready to enter the field, but also increases the time lag between demand and the preparation of the supply," Brown declared.

Harry Becker of Chicago, former UAW–CIO health insurance advisor and now a program consultant to Blue Cross plans, told the state association that *"hospitals cannot delay taking an unqualified position on the prepayment of arrangements of choice, nor can they postpone making their position known to the community.*

CLOSE TIE-IN

"The Blue Cross prepayment mechanism is the hospital's fiscal agent. The density of hospitals in an economic sense, is inseparable

(Continued on page 445)

Dr. Adolph M. Hutter, Fond du Lac (left), and Dr. Allan Filek, Madison (right), of the State Board of Health, are working on program planning for the first annual Wisconsin Governor's Conference on an Aging Population to be held on the University of Wisconsin campus in Madison June 6–8. They are shown above with U. W. Emeritus Professor John L. Gillin, 84, program chairman. The conventions of the Wisconsin Association for Public Health and the Public Health Council will be held in conjunction with the conference. Outstanding speakers, panel discussions and special meetings will comprise the three-day program, one designed to work out current problems and map plans for future activities. All of the state's organizations and agencies interested in the health and care of the aging population group are participating in planning activities relating to programming, housing and care of the hundreds of visitors expected to attend the session.

Wisconsin 10th in Med Education Gifts

Chicago — Wisconsin physicians, with contributions of $50,686, ranked 10th among all states in aid to medical education in 1955.

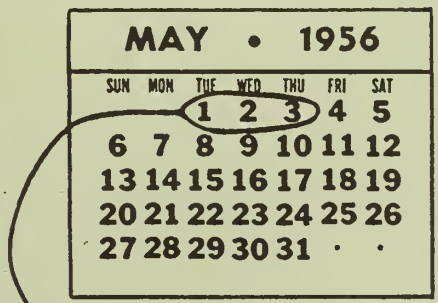
The American Medical Education Foundation reported that 76 Wisconsin doctors had contributed $3,628 to the Foundation, and 614 had sent $47,058 to directors of alumni associations.

ILLINOIS THIRD

New York physicians contributed $501,000 to lead all states. Pennsylvania was second with $358,312 and Illinois third with $256,286.

The full totals listed 57,060 doctors who sent $2,395,785. Another $100,000 was credited to the AMA, and $9,966 to miscellaneous sources.

The figures did not include donations for scholarship and research grants which were not interpreted as unrestricted gifts.



RESERVE FOR ANNUAL MEETING!!

ON THE S.M.S. CALENDAR . . .

May 1–2–3—ANNUAL MEETING, MILWAUKEE!
June 5—Claims Committees, SMS.
6–8—Governor's Conference on An Aging Population, Madison.
11–15—AMA Annual Meeting, Chicago.

DOCTORS WARNED: STUDY ADOPTION LAWS CAREFULLY!

Lawful Role of Physicians Detailed

Madison—"Doctor, I believe I'm pregnant," the young woman said haltingly.

She was right.

The physician learned she was from a nearby village, unmarried and wanted counsel. She also made it clear she had no intention of keeping the baby when it arrived, and wanted the doctor to help find a place to put it.

The doctor said he knew of a resort upstate where she could work as a dishwasher during the coming months, where no questions would be asked, and near a hospital where the delivery could take place.

MUCH PRESSURE

For the past three years, the physician had been hounded by a middle-aged couple who wanted a baby. Childless, they had tried one

A FORUM FEATURE

agency after another, without success.

Here was the answer. (So they thought!) The couple could acquire this infant, soon as the unwed mother left the hospital.

That's the way it happened.

UNLAWFUL PATTERN

The physician aided the young woman through her pregnancy and delivery period, and then turned over the newborn child to the couple when the time came.

ANY INFORMED M.D. KNOWS THIS FELLOW PRACTITIONER WAS BREAKING STATE LAW!

Wisconsin's new Children's Code proclaims a physician *must not*:

1. Suggest to any unmarried mother, a natural parent or guardian, any particular foster parents for a child whom he deems available for adoption;

CODE IS SPECIFIC

2. Offer to find foster parents for such a child;

3. Offer to find a child for adoption by prospective foster parents;

4. Place a child with foster parents on a trial or any basis;

5. Act in any other way as a negotiator or intermediary in such matters, and

6. In any other way risk possible violation of the Code, under penalties for violation.

Penalties for violating state law relating to adoptive procedures are punishable by fines up to $500, or imprisonment in a county jail up to one year, or both.

AUTHORIZATION VITAL

The law provides that children "may be placed for adoption only by a licensed child welfare agency or a public agency authorized to place children for adoption, or by the parent or guardian after obtaining written approval of a county court."

Nonauthorized persons, including physicians and lawyers, are *not* permitted to act as intermediaries in finding children for adoption or making placements. Lawyers in a professional capacity, may represent the parties and handle all legal details required by adoption statutes.

"ALL THE WAY"

In the years before World War II, a physician and a boarding house operator teamed up together to circumvent the law. Their system was quite profitable.

Many unmarried girls found their way to his office, located on a side street. He assured them he would take care of them *"all the way."*

The woman's "boarding house" was in another part of the city. Her own children had grown up and left home. The mothers-to-be stayed at her home and paid so much per week for their keep (part of which went to the doctor), and could leave after delivery, knowing their babies were in the hands of a "kindly, considerate" woman, who would find good homes for them.

PROFITABLE PLAN

Prospective parents also found their way to the doctor's office. He told them he knew of a place where unwed mothers had left their children for adoption, and if the "board" bill were paid, they could have an "addition" to their families before long. There was very little, if any, screening of the parents-to-be.

So the board bills were paid twice. Usually, the new parents were delicately pressured into giving the "housemother" several hundred dollars or more, when they picked up the infants. This, she said, was the "usual." It wasn't hard to get.

There was an attorney tied into the scheme, too. He worked for the couples in obtaining forged birth certificates from a county clerk's office in another state. His fee was higher than that of the doctor and boarding house operator.

Investigators found the arrangement hard to crack, but they did, shortly after the war.

Almost any physician in the state could cite numerous opportunities to get around the law. Almost all of them, fortunately, discard any thought of doing so.

SERVICES LISTED

The doctor's role, as explained in the first part of this two-part series on adoptions, includes medical testing and care, counselling as to proper placement, and understanding of the problems involved. His is a professional service.

This role of the M D. *cannot* be stressed too much. It is essential that he *avoid any conduct* which could cause him to appear in the view of the general public as associated in any way with the "black market in babies."

Even after acquittal in such cases, a dark cloud persists.

It's difficult to tell old friends they have to look elsewhere for the baby they want so much. And

(Continued on page 446)

SMS GROUP DISABILITY INSURANCE AIDED 15% OF MEMBERSHIP IN 1955

Incidence of Accidents, Illness Among Physicians Continues to Climb

Madison—Have any doubts as to the effectiveness and worthwhileness of the State Medical Society's Group Disability Insurance Program?

Read this:

During the last four months of 1955, a total of 126 Wisconsin physicians filed claims for disability under the policy underwritten by the Provident Life and Accident Insurance company.

ENROLLMENT HIGH

One Wisconsin doctor has been paid $10,699.29 during the past two years.

More than 1,750 Wisconsin physicians are now enrolled in the program.

More than $875,000 was paid in benefits between August, 1950, and last November 1.

Almost 15 per cent of the doctors enrolled were disabled for varying periods in 1955.

CLAIMS VARY

The protection is offered as an S.M.S. membership service. The insurance is available to all eligible Society members actively practicing medicine who are less than 70 years of age. Benefits for insured members are available through 74.

Claims paid during the last four months of 1955 included 19 afflicted with heart disease, eight with cerebral vascular accidents, six with back sprains,—six others suffering multiple injuries in vehicular accidents, five with cancer, five with hernias and five more with nervous depression. Forty-five listed an assortment of ailments, 30 suffered various accidents.

PROVISIONS LISTED

The basic program provides for payments of $75 per week for total disability resulting from an accident or sickness. Partial disability benefits are $37.50, and there also are substantial payments for accidental death and dismemberment. A physician will be allowed $10 per day while confined in a hospital and up to $100 to cover hospital expenses other than for room and board.

Provident also authorizes optional benefits of an additional $25 in weekly disability payments to members between 34 and 60—if the members do not carry more than $150 weekly indemnity under plans made available by reason of membership in other professional organizations.

Dr. E. M. Dessloch, Prairie du Chien, Chairman of the Commission on Prepaid Plans, conferred with another western Wisconsin M. D., H. W. Carey of Lancaster (right), at a recent meeting in the State Medical Society headquarters in Madison. Dr. Robert S. Gearhart (center), of Madison, Chairman of the newly-created Division on Safe Transportation, listens. Dr. Carey is Chairman of the Division on Public Assistance.

THE ONLY ONE

The Provident Plan is the only group disability program officially sponsored by S.M.S. It is believed the Wisconsin program continues to offer the most income protection benefits per dollar of premium charged.

The Plan has other advantages, too:

APPLY EARLY

Eligible members may subscribe without the health questionnaire . . . granted the applications are filed when they become eligible. New Society members under 32 may apply within a year of joining the state organization, those over 32 within six months. This is without consideration of present physical condition or past medical history!

A physician who does not buy the program when it is first offered to him may apply later—but the company then may accept or reject such application on the basis of a health statement which must be supplied at the applicant's expense.

Kenosha Society Uses Newsletter Effectively

Kenosha—The Kenosha County Medical Society is making excellent use of a newsletter to let its members know what's happening these days.

The County's Public Relations Committee, with Dr. Helen A. Binnie as secretary, began the bulletin this winter.

MAY 1, 2, 3!

A recent edition urged members to attend the Annual Meeting of the State Medical Society in Milwaukee, May 1–3, to show up at a County meeting, to give encouragement to high school science fairs and to keep informed on changes in health examinations. It also reported that current press relations with the city's newspaper were "excellent."

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE policies are not terminated nor are benefits reduced because of age.

T·I·C

TIME INSURANCE COMPANY

MILWAUKEE WISCONSIN

Dr. Robert C. Parkin, medical advisor to the State Medical Society and coordinator of post-gradaute medical education at the University of Wisconsin, is shown (left) at work on the Society's *March of Medicine* radio series which began its 11th year this spring. With Dr. Parkin, a specialist in public health, is Karl Schmidt, medical reporter on the program carried over 42 Wisconsin stations, and a regular announcer on the staff of WHA, the state station in Madison.—(Photo by Homer Montague)

DR. PINSMASHER!

Madison—Are you a bowler, Doctor?

Does the idea of a bowling tournament in some centrally-located city in which you'd roll against other MD's appeal to you?

Dr C. M. Carney, of Beloit, thinks it would.

He believes a tourney held in late March or early April 1957 would attract enough members of the State Medical Society to make the effort worthwhile . . . and a lot of fun.

Preliminary discussion centered around competition in singles only at the first tournement. Then if sufficient interest and registration warrants, the rivalary could be extended to doubles and teams.

It is likely the ABC would sanction the tournament, if it is held, and assist in handicapping the bowlers. The game average of 145 probably will serve as a minimum mark, with certified league averages, wherever available, utilized in classifying the entrants.

If you are interested, send this coupon to Dr. C. M. Carney, 405 East Grand Avenue, Beloit, Wisconsin. This doesn't sign you up for the tournament—it just indicates your interest and desire to participate in 1957.

Dr. Carney:

I like the idea of a doctor's bowling tournament. Put me down as one interested enough to participate in 1957 (if you give me enough warning).

(Signed)_____

(City)_____

Will we see YOU at the Annual Meeting of the State Medical Society in Milwaukee May 1–3?

Illinois Nursing Executive Action Problems Prompt

Madison — Wisconsin's neighbor state, Illinois, is apparently having some of the same problems with regard to nursing education as those providing serious concern to the State Medical Society.

According to a recent bulletin of the Illinois State Medical Society, "the serious problem resulting from a growing shortage of graduate nurses, the continued closing of more nursing schools in the downstate hospitals due to constantly upgrading rules and regulations governing such schools," has prompted the Illinois Council to appeal to the governor for help.

The Council of the Illinois Society recently went on record:

"That the Council of the Illinois State Medical Society request the Governor of the State of Illinois to appoint a separate commission composed of practicing physicians, nurses, hospital administrators, and educators to conduct a study of the critical shortage of schools of nursing and of teaching facilities within the state."

Governor William G. Stratton indicated that the proposal "appears to have merit." The Illinois Medical Society says the situation is acute in the downstate area. It reports that the smaller schools from which many able nurses have been graduated are continuing to find it more and more difficult to meet new demands and new rules and regulations being imposed upon them.

Firm Offers Oxygen Therapy Films, Aids

New York—The Linde Air Products Co., is offering a wide selection of films, charts, exhibits, lecture materials, bulletins, handbooks, tags, signs and surveys dealing with oxygen therapy.

These may be obtained, along with any information needed, without cost from the firm's Milwaukee office at 1623 South 38th street.

Films offered include Oxygen Therapy Procedures, Oxygen Dosage and Techniques, Physiology of Anoxia and Oxygen Therapy in Heart Disease, with running time ranging from 22 to 33 minutes.

Dr. M. H. Olson Reports On Vienna Medical Group Meeting

Wittenberg, Wis.—Dr. Marvin H. Olson, an official observer at the ninth general assembly of the World Medical Association in Vienna last fall, said he was most impressed by the stress on socialized medicine at the meeting.

Drs. Olson, Gunnar Gundersen, La Crosse and Henry E. Kasten, Beloit, represented Wisconsin at the sessions.

The Wittenberg physician said: *"A great deal of attention was paid to the important problems of socialized medicine. The reports on developments were heard from delegates of various countries. One thing emphasized by Dr. Dag Knutson, of Stockholm, was that the medical profession must state that medicine, an age-old art merged with the young science, should set its own conditions of practice, with social security systems assisting in the achievement of the ultimate goal.*

"I am very enthused about the WMA and the mission it is trying to perform. . . . it is one way we can help fight socialized medicine."

Dr. Olson said the main difference between the observers "seemed to be one of intensity, depending upon development and need. Also discussed were ethics, post-medical personnel and liaison between the press and the medical profession."

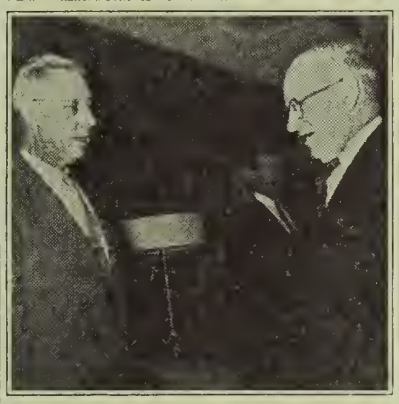
The Association, an organization of national medical associations, is a private, non-governmental scientific group supported only by dues and contributions.

NEW BOOKLETS AVAILABLE

Madison—Two booklets of vital interest to medical organizations, published by the AMA, are available through the offices of the *State Medical Society, P. O. Box 1109, Madison.*

One is **"Guides for Medical Society Grievance Committees,"** which reviews findings and recommendations of a special committee appointed by the AMA Board of Trustees. The second, **"Report of the Survey on County Medical Society Activities,"** includes data on meetings, budgets, educational programs, personnel, building facilities, work of committees and extent of public relations activities.

State Board Votes Approval for 19 Hospitals and Related Facilities



The matter of Salk polio vaccine distribution was the subject of a discussion bringing together Dr. Carl N. Neupert (left), Madison, State Health Officer, and Dr. Albion H. Heidner, West Bend, a past president of the State Medical Society, recently. Both gentlemen attended a meeting of the Council at Madison.

Madison — The green light for 19 projects for hospitals and related facilities construction, expected to cost an estimated $7,000,000, has been voted by the State Board of Health.

The federal government will provide $2,300,000 of the cost.

Largest amount, $1,489,950, was allocated for a new 96-bed Trinity Memorial Hospital to serve South Milwaukee and Cudahy.

The Board listed four proposed diagnostic and treatment centers, but explained that final sanctioning depended upon further screening, recommendations of area physicians and approval of hospital boards concerned. The out-patient services were outlined for Luther Hospital, Eau Claire; St. Francis Hospital, La Crosse; St. Michael's Hospital, Milwaukee and Sheboygan Memorial Hospital.

LIST FULL COST

Other categories of facilities, with total cost figures:

General Hospitals—Algoma Memorial, $105,500; Door County Memorial, Sturgeon Bay, $280,000; St. Mary's, Columbus, $310,000; St. Joseph's, Hartford, $425,000; Plymouth, $300,000; Stoughton, $633,000; Edgerton Memorial Community, $500,000; St. Francis, Milwaukee, $250,000.

Chronic Disease Facilities — St. Vincent's Hospital, Green Bay, $753,630, and St. Agnes, Fond du Lac, $350,000.

Nursing Homes — Boscobel Memorial, $60,000, and Tomah Memorial, $90,000.

Rehabilitation Facilities — Marquette University Dental School, Milwaukee, $262,000, and Curative Workshop of Milwaukee, $93,400.

Vote Honorary Membership for Dr. Shideman

Madison—Honorary membership in the State Medical Society has been accorded **Dr. Frederick E. Shideman**, director of the University of Wisconsin Department of Pharmacology.

NEW EDITOR

The Society's Council voted the membership February 26 to facilitate his assuming joint editorship of *The Wisconsin Medical Journal's* section on *"Comments on Treatment."*

Dr. Shideman received his M.D. from the University of Michigan in 1946. He was named department chairman two years ago.

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221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

SHORT TAKES

REMEMBER!
Your Annual Meeting in Milwaukee May 1, 2, 3

Tid-bits from the S.M.S. office in Madison:

Frank G. Dickinson, of the Bureau of Medical Economics Research, Chicago, recently wrote: *"The results of the 1953 Washington (state) Sickness Survey, a study of incidence of illness as seen by MD's in private practice, may well serve as a guide in the planning of undergraduate and postgraduate education, as well as focusing attention on the most significant health problems of the state. Disease prevention programs can scarcely be undertaken in all fields with equal vigor, so a comprehensive view of illness is necessary for the most effective utilization of research and education facilities."* . . . Operation of the S.M.S. Foundation brings problems. Its trustees currently are considering how to assist a physician who was completely paralyzed by polio, and his family. Contributions received this far are on loan to medical students . . . Rumor has it that recommendations may be forthcoming to hike A.M.A. dues . . . **Art Broughton,** on the editorial staff of the **Wisconsin Agriculturist and Farmers,** recently wrote: *"Farmers are always buying vitamins, minerals, vaccines and the services of a veterinarian for his livestock. BUT does he work as hard and spend as much to make sure he's going to be alive and kicking when the work's all done? Seems to me this might be a good time to drop in and let your family doctor give you a tune-up."* . . . **Artful advice** . . . According to reports from Washington, the Federal Department of Labor has drafted a proposed model workmen's compensation law. What would physicians think if another federal department would pop with a model medical practice act? Don't answer . . . we know. **April 19–20** marked the first meeting of attorneys for state and county medical societies. Held in Chicago, the program involved discussions re grievance committees, liability insurance, interprofessional relations of lawyers and physicians. Wisconsin was represented . . . *"Guides for Grievance Committees,"* an AMA publication OKd by its House of Delegates, is fresh off the press. It summarizes recommended responsibilities. If you are interested and need copies, write **S.M.S. P.O. Box 1109, Madison** . . . Since dedication last October (through March 1), fifty-one meetings have been held in the new home of S.M.S. **Have you scheduled a visit?** Write us for a map showing location and access via the Madison Beltline. You can drive to within a half mile of the building at country speeds . . . **The North Carolina Blue Shield** is offering a $4,200 and $6,000 family income service contract. **Colorado** will provide health examination benefits for those who have a three-year continuous membership. **The Wisconsin Blue Cross** has decided to permit sale through licensed brokers, and *Blue Shield* will follow suit. **See you in Milwaukee May 1–3.**

Set Average Fees, Doctors Advised

Toledo, O. — Establishment of average fees for medical service would stimulate further growth of voluntary health insurance coverage, a former AMA president believes.

Writing in the March *American Magazine,* **Dr. Edward J. McCormick,** Toledo, said "knowing what doctors would charge for their services would enable insurance companies to know what schedule of benefits to offer the public."

He said:

"This would bring about more realistic coverage as the degree to which policyholders might have to supplement their health insurance would become more predictable."

Dr. McCormick feels that physicians could establish schedules of average fees for common medical services on a local basis and make these fees known to the public. Because of economic factors, he doesn't believe uniform fees would be practical on a national or statewide basis but is convinced they could be worked out equitably on a county or regional level.

Dr. Peckham

Dr. Peckham Gets U.W. Medical School Post

Madison—The new chairman of the Department of Obstetrics and Gynecolgy in the University of Wisconsin Medical School is **Dr. Ben M. Peckham,** 40, who succeeds the late Dr. John Harris.

Dr. Peckham, who also will serve as chief obstetrician and gynecologist in the University Hospitals, has been a member of the Northwestern University Medical School faculty where he received his M.D. degree in 1942 and his Ph. D. in physiology in 1949.

TO CONTINUE RESEARCH

At native of Milwaukee, the new chairman, whose appointment was approved by the Wisconsin Board of Regents, will continue research in his field while in Madison.

Dr. Peckham is a member of the American Academy of Obstetrics and Gynecology, the Society for Gynecological Investigation, Sigma Xi Research Society and Nu Sigma Nu, medical fraternity.

Dr. Harris died in January, 1955.

You're Invited!

Madison—Wisconsin's rich heritage can best be preserved through the efforts of physicians and their wives working together with the Section on Medical History and the State Historical Society.

Your support and interest are needed to create a medical museum for Wisconsin; to collect valuable documents, diaries, letters, day books, equipment and other papers and artifacts; and to support the preparation of manuscripts recording medical history in the state.

You may join the Section on Medical History (dues $5. annually) by writing to the State Medical Society, Box 1109, Madison 1.

HOSPITAL COSTS . . .

(Continued from page 439)

from the destiny of Blue Cross. Hospitals will make or break Blue Cross."

Becker said that hospitals must take the leading role in selling Blue Cross to the public, and because of rising hospital rates, must help prepare the public for paying more for their hospital protection.

URGES EXTENSION

At the same time, Becker urged Blue Cross to extend benefits to include such items as out-patient visits and convalescent home care for services that can be provided on an ambulatory basis.

Looking to the future, Becker urged administrators to consider the hospital as the center of modern medical wonders in which the patient's physician will be the central force.

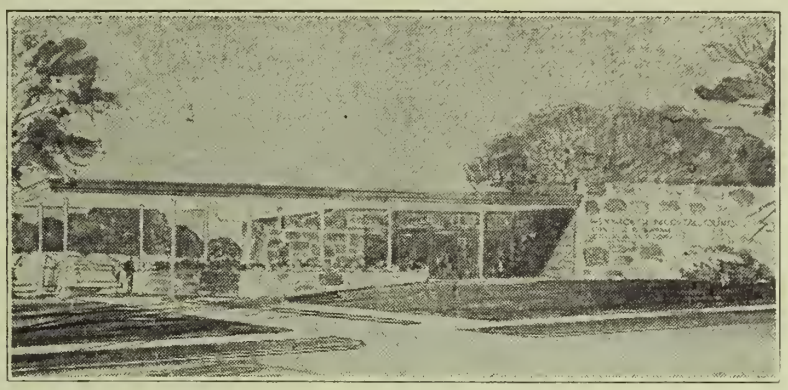
FUTURE PICTURED

"The hospital will be as concerned with keeping its constituents out of the hospital as it will be with treatment and rehabilitation of those who are admitted," Becker declared. *"There is increasing emphasis today in hospital literature on the future role of the hospital as a community center for health activities in the prevention and early detection of disease as well as for diagnostic services."*

During the course of a question and answer period at the meeting, several hospital administrators indicated that physicians and medical societies in their areas were seeking additional information on problems of accreditation. A State Medical Society representative present at the meeting assured the audience that any physicians seeking advice on accreditation of hospitals from the medical staff standpoint could receive aid from the State Medical Society office upon request.

MISS GRAHAM CITED

In other actions, the Hospital Association presented its annual award of merit to Miss Olive M. Graham, R.N., administrator of Wausau Memorial Hospital. She has been head of the hospital since it first opened in 1923. The award was presented by Dr. Harold M. Coon, Madison, superintendent of the Wisconsin General Hospital and a trustee of the Association.



Plymouth Physicians Build Clinic

Plymouth—Only a few months more, and Plymouth will have its first clinic.

Dr. Lloyd J. Steffan, a general practitioner, and Dr. H. A. Weisse, an obstetrician, mapped the plans for the Plymouth Medical Clinic several years ago. Last year they purchased two lots only a block away from the Plymouth Hospital and construction began last November. The hospital is starting construction on a 15-bed addition in May.

STAFF EXPANDING

Expected to cost in excess of $60,000, the clinic facilities will be such, Dr. Steffan said, that two or three more doctors could easily be added to the staff. One general practitioner is being sought currently to augment the clinic personnel.

No provisions were made for facilities for allied professions.

The clinic has x-ray and laboratory facilities, three offices and nine examining rooms. Zone heating and air conditioning are provided, and all adjoining walls are to be sound-proofed. Floors are of vinyl asphalt tile, and ceilings of acoustic tile.

CAREFULLY PLANNED

The walls of the front of the structure are of Lannon stone, with deep-raked jointing. The remainder of the building is redwood. Other features include clerestory-type windows, to afford maximum privacy; an entrance ramp over the driveway; a carport, and pilot lights above the doors of each examining room.

Dr. Steffan said the plan of the building is such it can be expanded easily. An architect's sketch of the Clinic is shown on this page.

Nursing Survey Ready This June

Milwaukee — The Wisconsin Commission for the Improvement of Patient Care has learned that a special survey report on nursing will be available this summer.

The Special Commission of the State Department of Nurses may make its findings available to the State Board of Nursing in June.

Also reported at a meeting in Milwaukee in February:

SACRED HEART ADDED

That plans for a trained practical nurse school in Wausau have been abandoned, but that a new TPN center, Sacred Heart of Milwaukee, had been added to the roster.

That the University of Wisconsin Medical School will take over a four-year degree course in nursing next September.

That the *Wisconsin Administration Code*, in which the Board defined comparable training, experience and preparation, is being distributed to Wisconsin nurses this spring.

That the State Department of Nursing is studying proposed minimum curriculum standards for nursing schools.

ASK "INVESTIGATOR"

That the Board of Nursing recently created the position of "investigator" but intends carrying on a program of education among nurses before filling the post.

That blood bank nurses are desirous of obtaining a special certificate or award from the State Board of Nurses to enable them to be recognized for the particular technical training which applies to their work.

That more and more TPN's graduating from school are going to small hospitals to practice.

ADOPTION LAWS . . .

(Continued from page 440)

when the friends come back with tales of woe, with details about being turned down by this agency and that one, the matter of saying "no" is that much more difficult.

DANGEROUS!

But it's extremely risky business for all concerned.

The State Department of Public Welfare's Division for Children and Youth will tell you that any childless couple with an average income, a suitable home, in good health and with a background of respectability, stands an excellent chance of obtaining a child from a recognized agency. The "tales of woe" lose some of their luster when the full story is told, when the actual reasons for the turndowns are learned.

The adoptive "team"—according to law—should consist of a physician, a judge, psychologist and a child welfare worker. There should be no short-cuts, no circumventing. Placing children for adoption is regarded as a process, not a single act.

ALABAMA ACTIVE

Last year the Medical Association of the State of Alabama adopted a resolution which urged that "all county medical societies carefully scrutinize any practice leading to the placement or referral of children for adoption by physicians, and that individual physicians use their influence to acquaint their patients to whom they provide professional service with the procedures of adoption as prescribed by law."

Mrs. Edward Gresham, director of the Alabama Bureau of Child Welfare, commented:

"I am sure each of you (the statement was directed to county directors of public welfare) *realizes the deep significance of the passage of such a resolution. I am likewise sure it will be continuously useful to us in our interpretation of the value of sound adoption placement practice.*

MD NO SOCIAL WORKER

"Apparently, the physicians of Alabama are increasingly aware that placements by authorized agencies provide a greater degree of safeguard and protection that other types of placements. You will perhaps wish to thank personally many of the local member of the State Medical Association for their attention to the adoption program and their desire that it shall proceed with sound practice."

The resolution also stated that the role of the physician "is *not* that of a social worker."

The Children's Code in Wisconsin, as strengtened and clarified by the 1955 legislature, declares the policy shall be that each individual child's interest is paramont, and that the interests of others concerned are secondary.

Physicians are urged, should questions arise concerning particular cases, to consult the Division of Children and Youth, State Department of Public Welfare, Madison. This is the state administrative agency in charge of such matters.

Who must give consent to an adoption, under Wisconsin law?

1. Both parents, if they are living, or the surviving parent of a legitimate minor. Consent shall not be required from one whose parental rights have been legally terminated; or

CONSENT VARIES

2. If the minor is illegitimate, the mother alone; provided that consent shall not be required from a mother whose parental rights have been legally terminated; or

3. If the minor has no living parent, or a nonresident parent has signed a release, the consent of the State Department of Public Welfare is required. If the minor's custody has been transferred by a court to that department or to a licensed child welfare agency or county home for dependent children, the consent of the appropriate agent is necessary. If the minor is a nonresident, the consent of the Wisconsin Department of Public is required.

4. The guardian of the minor, if there is one; and also

5. The minor himself, if he is 14 or older.

There are dozens of questions and possibilities revolving around each adoption. When these evolve, the smart thing to do is consult the law . . . and follow it.

Heart Meeting To Be Held in Madison June 2

Madison—The Wisconsin Heart Association will hold its annual meeting in Madison June 2.

Dr. Irving H. Page, president of the American Heart Association, will address a noon luncheon gathering. Dr Lester W. Paul, of the University of Wisconsin Medical School, also will speak.

Abbott Lab Offers New Technical Films

North Chicago, Ill. — A new series of medical films is available without cost to professional organizations through the Abbott Laboratories in North Chicago.

The films, most of them in color and ranging in length from eight to 45 minutes, are 16 mm. They include:

"Intravenous Anesthesia with Barbiturates," "Cardiac Arrhythmias," "Cell Division and Growth," "Value of Succinylcholine Chloride in Electroconvulsive Therapy and Laryngospasm,' "New Antibiotic Treatment for Intestinal Amebiasis," and *"Pentothal Sodium in Obstetrics."*

The films, or information about them, may be secured from the Laboratories or the State Medical Society of Wisconsin, Public Information Office, P.O. Box 1109, Madison.

Mental Health Films Available at No Cost

Philadelphia—Films on mental health are available on a loan-cost fee basis from the Smith, Kline and French Laboratories, as follows:

Mind and Medicine—A 50 minute filming of a clinical conference sponsored by the AMA and the American Psychiatric Association. It shows 10 case histories of patients before and after treatment sional groups.

Search for Sanity and *We, the Mentally Ill*—two *March of Medicine* telecasts, produced in cooperation with the AMA. These are each 30 minutes, sound, black and white.

Requests should be forwarded to Shirley Winters, Film Center, SKF Laboratories, Philadelphia 1.

Treatment of a Five-Pound Infant With Congenital Esophageal Stenosis*

By RICHARD H. SEGNITZ, M. D.**
Milwaukee

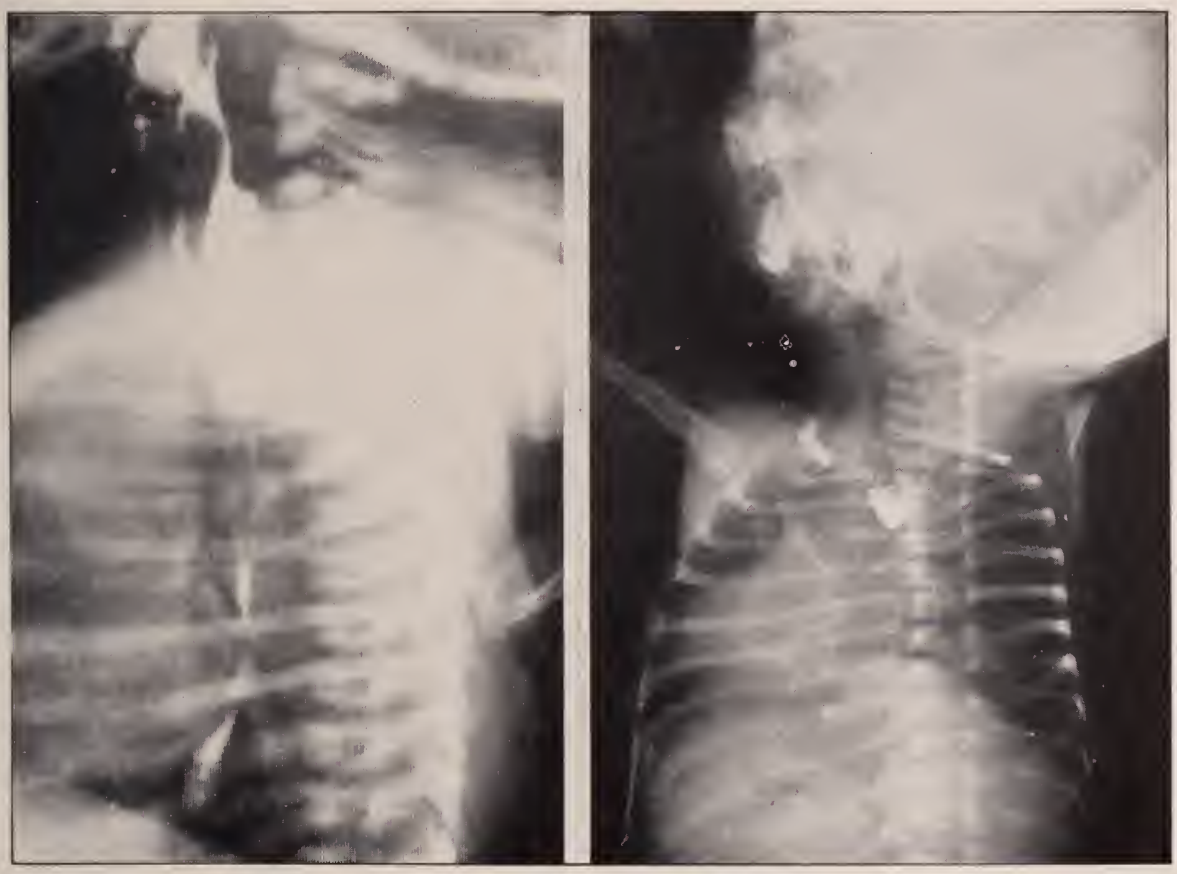


Fig. 1a—Lipiodol esophagram on May 2, 1955, showing a marked stenosis in the upper third of the esophagus. 1b—Lipiodol esophagram one week later, showing complete esophageal obstruction at the level of stenosis.

CONGENITAL esophageal stenosis is relatively uncommon; this pertains particularly to upper third lesions at the usual site of esophageal atresia associated with a tracheo-esophageal fistula. The occurrence of a very marked stenosis at this level in a five-pound baby and its successful management by thoracotomy and esophagoplasty seem worthy of a brief report. Much of the credit for the successful management of this case should go to Dr. Robert Kass, resident in the Department of Pediatrics at Milwaukee County General Hospital, who saw this infant falter at three weeks of age and rapidly established the diagnosis while maintaining the infant in fine general condition.

Until recent years all but the most stubborn strictures of the esophagus in infants and children have been treated by repetitive bouginage. We are in entire agreement with this general concept when it pertains to post-operative stenosis (atresia with fistula), lye burns, and most congenital strictures. However, esophageal dilatation, which usually requires endotracheal anesthesia, is not without risk, particularly in infancy. It is equally certain that facing frequent readmissions for

* From the Surgical Service (Pediatric) of the Milwaukee County General Hospital and the Department of Surgery, Marquette University School of Medicine, Milwaukee.

** Markle Scholar in Medical Science.

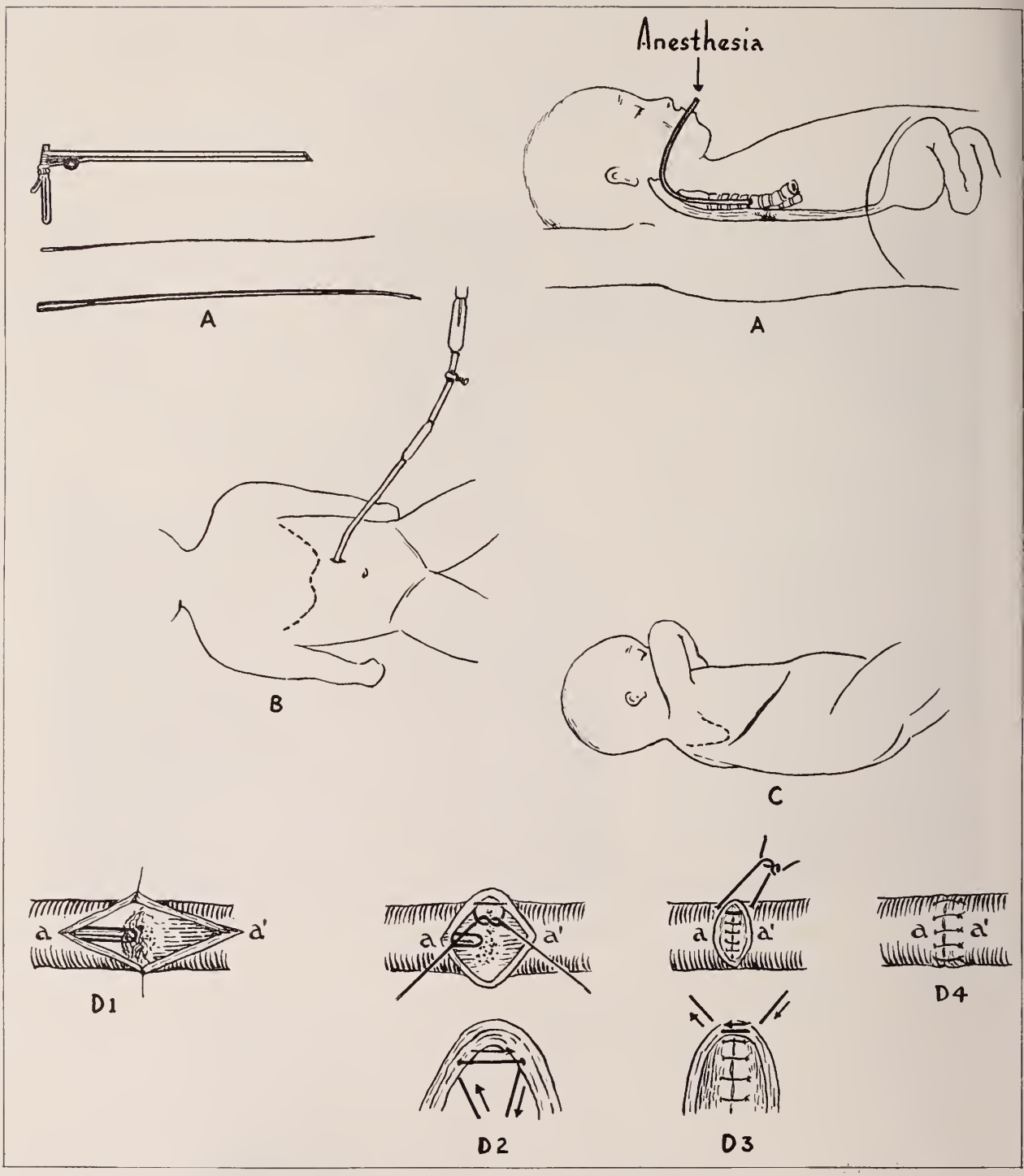


Fig. 2—Operative steps utilized: (a) Esophagoscopy and attempted filiform dilatation of the stenosis under endotracheal anesthesia. (b) Stamm type gastrostomy performed. (c) Incision for thoracotomy is shown. (d) Details of esophagoplasty demonstrated.

this maneuver, often without much evidence of progress, the family involved is taxed to the maximum. When, therefore, there is a case with an exceedingly tight stenosis and the block is readily defined as limited in length (even diaphragmatic in nature), an aggressive open surgical attack may be warranted.

It is felt that in the following case report therapy tailored to fit the individual is depicted, and that the infant's course to date speaks well for resorting to an open surgical approach under the circumstances illustrated.

Case Report

B. C. was born uneventfully on April 9, 1955, weighing 5 pounds, 2 ounces. She prospered during the first two weeks of life, but then began to regurgitate feedings, the weight gain ceasing. Despite the regurgitation of ingested formulae, which were hastily adjusted without success, no sign of aspiration pneumonitis appeared. Parenteral fluids were begun and a Lipiodol swallow performed under fluoroscopy. The diagnosis was then readily apparent, the esophagram showing the marked upper third esophageal stenosis (fig. 1a).

On May 2, 1955, esophagoscopy was performed under endotracheal cyclopropane-ether anesthesia (fig. 2a). The stricture was approached, but repeated attempts to pass a filiform dilator were unsuccessful. A Stamm type of gastrostomy was then performed to maintain the infant (weight 5 pounds, 14 ounces) and put the area of stenosis "at rest" (fig. 2b). Conservative dilatation of the stenosis was still planned.

To guard against aspiration pneumonitis the infant was kept in the head-down position, suction was used around the clock, and penicillin was continued. She again prospered. One week later a Lipiodol swallow was repeated, now showing complete "shut down" of the stenotic area (fig. 1b). To visualize the lower two-thirds of the esophagus and confirm the diaphragmatic nature of the stenosis, the stomach was filled with thin barium, and the pharynx irritated; the regurgitated barium clearly defined a sturdy distal gullet (fig. 3).

With the infant gaining weight (6 pounds, 2 ounces) and the esophageal stricture quite obviously weblike, operative removal of the obstruction was deemed in order. Early operation was elected to avoid pulmonary complications which constantly concerned us because of the child's inability to handle her oral secretions. The presence of a tracheoesophageal fistula seemed unlikely, but could not be definitely ruled out.

On May 13, 1955 (the patient now 34 days of age), endotracheal cyclopropane-ether anesthesia was given and the stricture approached through a right posterolateral thoracotomy (fig. 2c). The exact site of stenosis was identified by passing a No. 14 Levin tube down as far as it would go. The tube was readily palpable; the esophagus externally seemed quite normal. The esophagus was mobilized after dividing the azygos vein, and then opened longitudinally at the tip of the tube as shown in figure 2d. The block consisted of a web, below which lay a 2 mm. plug of granular tissue, perhaps partly of inflammatory origin (fig. 2d1). After excision of the web and granulations, transverse closure of the longitudinal incision was done

Fig. 3—Preoperative regurgitation barium esophagram showing normal distal esophagus.

Fig. 4—Postoperative barium esophagram May 23, 1955, shows an adequate passageway.

in two layers with No. 5–0 arterial silk (atraumatic). The inner layer included mucosa and submucosa with the knots placed on the inside (fig. 2d2–d4). The Levin tube, advanced downward, was kept in position during the suturing to assure an adequate passageway. The mediastinal pleura was reapproximated over this closure with a residual defect for drainage into the pleura. An intercostal tube (No. 20) was then brought out from the pleural cavity for water seal drainage in the event esophageal leakage should occur.

The infant's postoperative course was entirely uneventful. Minimal fluids (approximately 30 cc./lb.), including 75 cc. of whole blood, were given via a cut-down in an ankle vein during operation and for 24 hours postoperatively. Gastrostomy feedings through a Murphy drip (left open at all times) were then begun, and weight gain was resumed over the next seven days (fig. 2b). Oral intake was then begun, at first small amounts of dextrose in water and then formula, with rapid discontinuance of gastrostomy feedings. The intercostal chest tube was then removed.

The chest wound healed primarily, and examination and x-rays of the chest showed the lung fully expanded. The infant was discharged with the gastrostomy tube in place (but clamped off) on the twelfth postoperative day. A barium swallow done before discharge showed no significant constriction at the site of esophagoplasty (fig. 4).

Since discharge this child has gained weight rapidly (0.5 lbs./wk.) and takes her formula without regurgitation. The gastrostomy tube was removed six weeks postoperatively after a repeat barium swallow again showed an adequate passageway.*

Comment

The lesion found in this infant and depicted in figure 2 would appear to be a type of enteric canal–lung bud dysplasia similar to the more complete "missbildung" of esophageal atresia with tracheo-esophageal fistula. Usually congenital esophageal stenosis occurs at a lower level, probably being a simple dysplasia of the enteric canal. It is these latter lesions that become manifest at a time when solid food or some misdirected toy becomes lodged at the point of maximum narrowing.[1] The children may have been "feeding problems" since infancy; but until a definitive diagnosis by barium esophagram following relief by esophagoscopy becomes available, the true meaning of the child's status is not appreciated.

Esophageal narrowing of this nature (uncomplicated and incomplete) can be readily overcome by careful dilatations, usually one to six in number, over a period of at most a few years.[2] Should the stenosis prove resistant and growth of the child fail to widen the channel, an operative approach may then be in order.[3, 4]

The same might be said for the stenosis following end-to-end anastomosis of the esophagus for atresia with fistula. Transthoracic esophagoplasty may be in order if the fibrosis at the suture line seems unrelenting or even progressive; on occasion this may be associated with a recurrent tracheo-esophageal fistula.

* This child has been followed for almost a year now. She takes solids well, and an esophagram is quite normal.

In recent years a few authors have advocated radical attack on lye burns of the esophagus. A program of early dilatation will, in the first place, avoid this issue. Should therapy fail to prevent the picture of a long tortuous stricture, resorting to resective surgery is seldom justified in this age group. A program of dilatation, either retrograde or over a string from above, abetted by the growth of the child, avoids the adventure of removing a long stretch of the gullet embedded in a fibrous mediastinum. Also averted is the subsequent esophagitis ushered in by a displaced cardio-esophageal sphincter mechanism.

In like manner the stricture of the lower esophagus brought on by the reflexing esophagitis of a sliding esophageal hernia should be managed by conservative measures. Correction of the herniation and, if necessary, bouginage should obviate the need for radical resective surgery.

Summary

1. The management of a congenital upper third esophageal stenosis in a five-pound infant is presented.

2. Conservative dilatation may be abandoned and esophagoplasty resorted to in certain types of esophageal stenosis in infants.

Milwaukee County Hospital.

The author wishes to thank the Art and Photography Department of Marquette University School of Medicine and Milwaukee County General Hospital for photographs and drawings shown in this paper.

REFERENCES

1. Holinger, P. H., Johnston, K. C., and Greengard, J.: Congenital anomalies of esophagus related to esophageal foreign bodies, Am. J. Dis. Child. 78: 467–476 (Oct.) 1949.
2. Potts, W. J.: Congenital deformities of esophagus, Surgical Clinics of North America 31:97–116 (Feb.) 1951.
3. Gross, R. E.: Treatment of short stricture of esophagus by partial esophagectomy and end-to-end esophageal reconstruction, Surgery 23:735–744 (May) 1948.
4. Tuttle, W. M., and Day, J. C.: Treatment of short esophageal strictures by resection and end-to-end anastomosis, J. Thoracic Surg. 19:534–537 (April) 1950.

POSTGRADUATE CLINIC ON SURGICAL CARDIAC DISEASE
MILWAUKEE COUNTY HOSPITAL

Date: Saturday, May 12.

Time: 10 to 12 a.m.

Program: "Life Cycle of Patients with Rheumatic Heart Disease"

Dr. Francis D. Murphy, Professor and Chairman, Department of Medicine, Marquette University School of Medicine, and Medical Director, Milwaukee County Hospital.

"Laboratory, X-ray, and Electrocardiographic Findings in Patients with Rheumatic Heart Disease"

Dr. Francis F. Rosenbaum, Assistant Clinical Professor, Marquette University School of Medicine

"Physical and Phonographic Findings of Mitral Stenosis"

Dr. George Hellmuth, Associate Professor of Medicine, Marquette University School of Medicine, and Chief of Section of Cardiology, Milwaukee County Hospital

"Hemodynamics in Heart Disease"

Dr. John Huston, Instructor of Medicine and Director of Cardiac Catherization Clinic, Milwaukee County Hospital

Special Guest—Dr. Dwight Harken, Boston

Doctor Harken will discuss indications for, and results in, the surgery of mitral stenosis and in mitral insufficiency. The operation which he has developed for the correction of aortic stenosis through an opening in the aorta to which a nylon sleeve has been sutured will be illustrated and discussed. Surgical correction of aortic insufficiency will be mentioned and the use of the heart pump illustrated.

The program will be moderated by Dr. David W. Barrow, Professor of Surgery, Marquette University School of Medicine.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Intestinal Obstruction

The patient with intestinal obstruction presents one of the more difficult problems confronting the anesthesiologist. The assessment and proper handling of all phases of altered physiology in this condition is a challenge not only to the anesthesiologist but to the surgeon as well. Aside from the ever-present danger of regurgitation and possible fatality during anesthetization, there are important changes in physiological mechanisms which increase surgical risk. Dodd[1] has placed these into four categories: (1) respiratory; (2) electrolytic; (3) hemodynamic; and (4) nutritional. Several cases from the Wisconsin Anesthesia Study Commission will illustrate some of these changes as well as demonstrate the absolute necessity for definite precautionary measures before administration of any anesthetic agent.

Case 72.—An emphysematous white male was admitted to the hospital because of rectal bleeding, a 20-pound weight loss, and a rectal lesion. The blood pressure was 150/70, and an electrocardiogram showed changes consistent with coronary insufficiency. An exploratory operation revealed invasion of the bladder by a rectal tumor, and a rectosigmoid resection and colostomy were done. Anesthesia was accomplished with cyclopropane-ether by the endotracheal technique and was complicated by hypotension and copious pulmonary secretions requiring frequent tracheal aspirations.

The patient did well until the fourth postoperative day, when he developed cough, vomiting, and abdominal distention with a serosanguineous drainage noted from the wound. The following day he was apprehensive and dyspneic with rapid, noisy respirations at 48 per minute and a pulse rate of 128. Slight cyanosis was improved with oxygen therapy, and gastrointestinal suction through a Cantor tube was instituted. An x-ray of the chest at this time was interpreted as showing no change. An abdominal film showed a dilated bowel. Blood studies that day were as follows: hemoglobin 11.9, red blood cells 3,980,000, nonprotein nitrogen 67, creatinine 2.7 mg.%, carbon dioxide 26 mEq., chlorides 105, sodium 144, and potassium 2.15.

An emergency exploration for repair of wound dehiscence and intestinal obstruction was scheduled the seventh postoperative day. On arrival in the operating room the patient appeared alert. He had a "wet cough" and marked abdominal distention. Beginning at 3:45 p.m. he was given atropine 0.4 mg., Demerol 75 mg. in three divided doses, and Nembutal 25 mg. intravenously. During this time the pharynx and larynx were anesthetized using 2 per cent Xylocaine solution. The blood pressure rose from 130/80 to 150/80, and the patient became drowsy although still fairly responsive. The trachea was intubated easily with a No. 10 Magill cuffed endotracheal tube with the patient still conscious. This produced vigorous coughing; and large amounts of thick, green sputum poured from the tube. Pentothal 75 mg. and then 50 mg. was given to produce unconsciousness, and the patient was given oxygen intermittently. Nitrous oxide, oxygen, and small amounts of ether were used to maintain some quietness until the tracheobronchial tree might be well cleansed. At 4:27 Flaxedil 80 mg. was given intravenously, and 60 mg. was given at 4:50. Artificial respiration was done with a nitrous oxide-oxygen mixture continued by semiclosed system. The operation began at 4:37 and consisted of exploration of the abdominal cavity, decompression of the small bowel, and closure of the wound dehiscence. At 5:10 a massive regurgitation of intestinal contents occurred around the Cantor tube, which then was replaced with a Levine tube. There was no evident contamination of the respiratory tree

system. Blood pressure fell to 90/70. The operation was completed at 6:35 p.m. Recovery was slow but uneventful.

* * *

Case 73.—An abdominal perineal resection was performed on a male patient for adenocarcinoma of the rectum. Anesthesia was accomplished with a combination of nitrous oxide, cyclopropane, and ether. No difficulties occurred. Several days later, after half of the wound sutures had been removed, distention developed; and a diagnosis of dehiscence with obstruction was made.

The patient was reanesthetized on the tenth postoperative day for correction of the obstruction. Nitrous oxide and ether were given by to-and-fro absorption technique. The level of anesthesia was deep third plane for two hours during resection and re-anastomosis of the small bowel. Distention was marked; a splanchnic block was done by the surgeon using 20 cc. ½% procaine in an attempt to reduce the dilatation. There was obstruction of the ileum where a loop of small bowel had been caught in the repair of the posterior part of the wound. Free mineral oil was present in the peritoneal cavity. Anesthesia had been discontinued when the patient had a massive regurgitation of liquid material. Respiratory obstruction occurred, and he became pulseless; the heart beat was inaudible. He was intubated and tracheal aspiration performed. Within a few seconds the heart beat was audible again, and spontaneous respirations resumed. Less than three minutes had elapsed since the regurgitation. Although reflexes were present, pupils remained dilated and fixed. Athetoid movements of the upper extremities occurred. The patient expired 16 hours after the operation. Autopsy showed cerebral and pulmonary edema and minimal aspiration of fecal material.

Discussion

Both these cases are good examples of the marked alterations in normal physiology which rapidly occur in intestinal obstruction. Inadequate respiratory exchange with hypoxia, anemia, and changes in blood chemistry were present and were evident especially in the first individual.

The distention which accompanies intestinal obstruction leads to limited diaphragmatic excursion and basal atelectasis. This results in a reduced tidal volume with inadequate respiratory exchange. The patient suffers from hypercarbia and asphyxia. Where peritonitis exists, splinting and rigidity of the abdominal muscles decreases inspiration even more. Frequently, patients with marked distention exhibit cyanosis and gasping respirations. Atmospheres high in oxygen are essential; and during anesthesia artificial means for adequate ventilation must be provided.

Dehydration and deficiencies in electrolytes should be corrected before the patient ever reaches the operating room. Fluid loss of salt water occurs as a result of prolonged vomiting or through gastrointestinal drainage by suction. Besides salt water, protein is lost into the intestinal wall and into the peritoneal cavity. The patient may enter a state of negative nitrogen balance very rapidly.

A shocklike picture is a part of intestinal obstruction.[1, 2] The distention causes reflex action with a fall in blood pressure. The additional abdominal pressure decreases venous return. There is plasma and salt loss, and the circulating blood volume is diminished markedly. Actual blood loss may occur when obstruction is complicated with peritonitis. All these factors produce a very labile vascular system.

It is difficult to correct completely the nutritional alterations. Children rapidly develop ketosis following cessation of intake and should be given dextrose early. In acute obstruction glycogen becomes depleted, while chronic obstruction is characterized by hypoproteinemia, avitaminosis, and anemia.

The tragic outcome of the second case emphasizes the need for definitive steps before rendering the patient unconscious and unable to protect his own airway. The prevention of vomiting with aspiration, and even drowning, should be the foremost thought of the anesthesiologist. Vomiting in intestinal obstruction is always a threat. The mechanism is initiated easily by the central action of the anesthetic drugs, anoxia, and stimulation during light anesthesia.[3] The presence of stomach or duodenal tubes is no assurance that the stomach or bowel is or will remain empty. One series

of studies showed that 12.1% of anesthetized patients with functioning gastric tubes regurgitated and 5.2% aspirated stomach contents.[4] Endotracheal anesthesia with rapid induction is the safest procedure.[1, 2, 5] Tracheal intubation with a cuffed tube under topical anesthesia should be done while the patient is awake or mildly sedated. The majority of patients will cooperate if the gravity of the situation is explained to them. Additional use of a pharyngeal pack is recommended. Cyclopropane or ether allow the needed high oxygen atmosphere.

The use of Pentothal Sodium alone or combined with relaxants is not indicated. Pentothal is a respiratory and circulatory depressant and is a poor agent in shock. Drugs such as curare may cause relaxation of the esophageal sphincters with a flood of gastric contents drowning the patient. One should be very cautious, too, in the use of depressant drugs as premedication. Spinal anesthesia does not avoid the problem of regurgitation and, in patients with incompletely decompressed obstruction, is contraindicated. Decreased respiratory exchange and circulatory depression are enhanced by the high level of anesthesia necessary for relaxation. The ability of the body to compensate for blood volume changes is altered. Many think, too, that the parasympathetic effect of spinal anesthesia may increase the danger of actual rupture of the bowel.[1, 2]

Postoperatively, the patient should not be returned to the ward until his condition is stabilized. Oropharyngeal oxygen is recommended in an attempt to decrease formation of intestinal gas and aid the depressed respiratory and circulatory systems.[2]

Summary

Certain safeguards must be initiated in the anesthetic management of patients with intestinal obstruction:

1. Preoperative deficiencies in electrolytes and dehydration should be corrected before any anesthesia is administered.

2. The stomach should be empty and gastrointestinal drainage continued.

3. After endotracheal intubation of the awake patient, anesthetization should be accomplished with a rapidly acting agent.

4. The use of Pentothal, other depressant drugs, and relaxants is not indicated.

5. Spinal anesthesia is contraindicated in the markedly distended patient.

6. Good postoperative care of the patient is essential.

REFERENCES

1. Dodd, Robert B.: Problems in anesthesia for intestinal obstruction, South. M. J. 45:805–810 (Sept.) 1952.

2. Collins, Vincent J.: Anesthesiology, Philadelphia, Lea & Febiger, 1952, pp. 404–405.

3. Morton, H. J. V., and Wylie, W. D.: Anaesthetic deaths due to regurgitation or vomiting, Anaesthesia 6:190–201; 205 (Oct.) 1951.

4. Culver, G. A., Makel, H. P., and Beecher, H. K.: Frequency of aspiration of gastric contents by lungs during anesthesia and surgery, Ann. Surg. 133:289–292 (March) 1951.

5. Mousel, L. H.: Preoperative preparation and choice of anesthetic agents, Anesthesiology 11:495–499 (July) 1950.

(Continued from page 430)

4. Whitehouse, W. M., and Holt, J. F.: Paradoxical expiratory ballooning of hypopharynx in siblings with bilateral choanal atresia, Radiology 59:216–220 (Aug.) 1952.

5. Pancoast, H. K.: Roentgenology of pharynx and upper esophagus, Am. J. Cancer 17:373–395 (Feb.) 1933.

6. Hay, P. D., Jr.: The Neck, Ann. Roentgenol. 9: 87–88, New York, Paul B. Hoeber, Inc., 1930.

7. Stewart, J. P.: Congenital atresia of posterior nares, Arch. Otolaryng. 13:570–583 (April) 1931.

8. Schaeffer, J. P.: Various types of congenital atresia of nose, Transactions, American Laryngologic Association 56:126–132, 1934.

9. Pastore, P. N., and Williams, H. L.: Congenital occlusion of nasal choanae: brief review of 12 cases, Proc. Staff Meet., Mayo Clin. 14:625–627 (Oct. 4) 1939.

10. Lederer, F. L.: Choanal atresia, in Diseases of the Ear, Nose, and Throat, ed. 2, Philadelphia, F. A. Davis Company, 1939, pp. 365–367.

11. Schwartz, A. A., and Isaacs, H. J.: Congenital atresia of posterior nares; report of 2 cases, Arch. Otolaryng. 35:603–612 (April) 1942.

12. Boyd, H. M.: Congenital atresia of posterior nares; descriptions of technics used in meeting operative difficulties and report of case, Arch. Otolaryng. 41:261–271 (April) 1945.

13. Caffey, J.: Pediatric X-ray Diagnosis, ed. 2, Chicago, Year Book Publishers, Inc., 1950, pp. 76–77.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Robert S. Haukohl, M. D.

Presentation of Case*

History: The patient, a 53-year-old male, was admitted to the hospital on August 12, 1954, complaining of shortness of breath and chest pain. The illness had begun one year before admission, when he developed intermittent chest pain, shortness of breath, and paroxysmal nocturnal dyspnea. At that time his blood pressure had been 156/96. Three weeks before admission the chest pain and shortness of breath had become worse, and he had complained of edema of the ankles and face, enlargement of the abdomen, and right upper quadrant abdominal pain. His blood pressure then had been 124/84, and his physician had found an occasional skipped beat. The heart rate had been rapid with a loud blowing systolic murmur at the apex. On admission the patient denied chronic cough or hemoptysis. A systemic review was essentially negative. There was no history of diabetes, tuberculosis, or rheumatic fever. He had stopped smoking four weeks before admission and used alcohol only occasionally.

Physical Examination: Temperature, 97 F.; pulse, 100; respirations, 24; blood pressure, 120/80. **General:** Well-developed, well-nourished white male in no acute distress lying in an orthopneic position. **Head and Neck:** Negative. **Lungs:** Clear to percussion. Fine moist rales heard over both lung bases. **Heart:** Rate 80, rhythm regular. Grade III harsh blowing systolic murmur heard best at apex and fourth left interspace, no palpable thrills. **Abdomen:** Obese, soft. Liver palpable 4 fingerbreadths below right costal margin, tender. No other findings. **Genitalia and Rectal:** Negative. **Extremities:** Two plus pitting edema, pretibial area and feet.

Laboratory Examination: Urine: Normal. **Kline Test:** Negative. **Blood:** Hemoglobin 17 gm. (110%), red blood cells 6,000,000, white blood cells 12,800. Differential: Normal. **Nonprotein Nitrogen:** 61.5 mg.%. **Electrocardiogram:** (7–21–54) Myocardial damage based on Q and ST-T wave changes suggestive of recent posterior wall myocardial infarction. (8–13–54) Myocardial damage on basis of R-T and Q changes. Improvement since first electrocardiogram. Probable recent infarction, posterior.

Course in Hospital: On August 13 the patient was seen by a consulting internist who found "Patient sitting in bed, dyspneic with cyanotic lips. Face looks puffy. Loose cough. Afebrile. Chest: few rales bases of lungs, more on right. Heart enlarged, tone quality good, loud systolic apical murmur, rate increased, regular. Abdomen slightly distended, liver 2 fingerbreadths below right costal margin, tender, no ascites, no other masses, spleen not palpable. Extremities: edema 1 plus, ankles."

The patient was treated with Crystodigin, 0.1 mg. two times per day; Thiomerin, 2 cc. subcutaneously daily; bed rest; Seconal; and Citrocarbonate. On August 13 Combiotic was begun, and aminophylline suppositories were prescribed. Cyanosis was prominent, and oxygen was necessary continuously. Dyspnea was less and color better with continuous oxygen.

On August 14 Combiotic was discontinued and Achromycin started. Crystodigin dosage was increased to three times per day, and Thorazine given intramuscularly. On August 15 the patient was much worse. He was markedly cyanotic and dyspneic in spite of oxygen. The abdomen began filling with fluid, as did the lungs. Thiomerin was discontinued and Mercuhydrin, 2 cc. intravenously, prescribed. Crystodigin was increased to 0.4 mg. intramuscularly.

On August 16 the patient was more dyspneic, a precordial systolic murmur was noted, the skin was pale and moist, the radial pulse was not palpable, and the apical pulse was 138. The patient expired at 7:30 a.m. in spite of Coramine given intravenously and intramuscularly.

* From Evangelical Deaconess Hospital, Milwaukee

Clinical Discussion

Dr. Abraham Marck, Radiologist: Early in 1953 this patient had had a gallbladder and upper gastrointestinal study, both of which were within normal limits. At that time also, we had obtained a film of the chest which showed elevation of the left diaphragm and adherence of the periphery of the left diaphragm to the lower left chest wall. There was also evidence of moderate pulmonary emphysema as evidenced by hyperillumination of the lung fields bilaterally, increase in the anteroposterior diameter of the chest, and flattening of the diaphragmatic leaves. In October of 1953 a follow-up film showed a small nodule in the left midlung field which did not change in subsequent films and was, therefore, considered to be inactive, although the nature of the lesion was not clear. The pleuritic disease already described showed no change in subsequent months. The film of November, 1953, was essentially the same as the others. The last film we have was taken in August, 1954, at the bedside and is therefore considerably distorted. The heart, however, is probably enlarged despite the magnification which would appear in this type of film. No changes are apparent in the lung fields.

Dr. Louis W. Sennett, Internist: Examination of this protocol reveals the story of a 53-year-old white male who was in apparent refractory congestive heart failure manifested by progressive dyspnea, orthopnea, precordial distress, cyanosis, ascites, and edema. He had been treated at home for several weeks with digitalis and Mercuhydrin without benefit, and was finally admitted to this hospital with the diagnosis of "cardiac."

Upon his admission to the hospital the record indicates that he continued to be treated rather vigorously with increasing amounts of digitalis and diuretics until his death. Combiotic and Achromycin were also given shortly after admission, although the indication for the antibiotics is less clear. Of all the treatment given to this patient, the record indicates that only the oxygen offered some benefit. However, in spite of all these efforts the patient seems to have died of total cardiopulmonary collapse.

Examination of the laboratory data discloses the interesting findings of polycythemia and moderate azotemia. Unfortunately, no studies of the blood electrolyte balance were done; this, of course, is of some importance in an evaluation of refractory congestive heart failure, especially in view of the mercurial diuretics given for a rather long period of time.

As discussed by Doctor Marck, the chest x-rays disclose an enlarged heart and, of some importance but not mentioned, a relatively normal pulmonary vascularity rather than marked pulmonary congestion as one would ordinarily expect to find with the extent of this patient's illness.

Up to this point no mention has been made of the etiology of this patient's heart disease. For the key to this problem we must turn to the electrocardiograms. There were two electrocardiograms, taken approximately three weeks apart and interpreted by two different individuals, both reading the tracings as recent posterior wall myocardial infarction and probable posterior wall infarction with improvement. If these interpretations are correct, then we have to explain why the patient's symptoms are those of predominantly right ventricular failure when the disease is in the left ventricle. It is true that the patient was orthopneic and cyanotic, but these symptoms are again peculiar and must be explained in the presence of relatively clear lung fields. In addition, with congestive heart failure due to myocardial infarction it is peculiar that the lung fields should remain clear until terminally. Under these circumstances, the clinical and radiologic findings do not square with the electrocardiographic interpretations, but do correlate beautifully with the electrocardiograms:

Lead I, Diphasic QRS with R, T up.
Lead II, Tiny Q; prominent R, and rather prominent P wave.
Lead III, Deep QS, small R, and relatively flattened T wave.
aVr QRS—diphasic
aVl normal

aVf—As you know aVf is very important in evaluating the QRST complex in V3, particularly when one is looking for a posterior wall myocardial infarct. Whereas Lead III ordinarily is the lead of exceptions where one may have a deep Q, normally, we must examine Lead aVf in order to help us determine whether the Q in Lead III is of abnormal significance. In this particular instance, I call

your attention to the M waves, small Q, small R, and small S with upright T waves. This finding would not necessarily be consistent with a recent posterior wall myocardial infarct in which we would like to see an inverted T wave. Here the T wave is rather prominent.

I want to call your attention to the findings in V1 which I believe are the key to the whole problem. The tracing is definitely abnormal and spells one thing; this patient has right ventricular hypertrophy. We see the classic right heart strain pattern manifested by the tall R wave, slight depression of the ST segment, and a classic heart strain T wave inversion. We sometimes find an inverted T wave in V1 which in itself may be within normal limits, but the classical QRS is mainly inverted with a small R and deep S. In this case as we progress from the right side of the heart to the left, the R wave becomes progressively smaller, the S wave becomes progressively deeper, the P wave becomes biphasic in a minus-plus direction, and the ST is rather depressed. In V4 and V6 you will note that the R wave is getting progressively smaller and the S wave is getting progressively deeper; and in V6 the T wave becomes upright. This is the classic pattern of right ventricular hypertrophy. There is nothing in the electrocardiogram, to my way of thinking, which would confirm the diagnosis of posterior wall myocardial infarction.

Another electrocardiogram was taken three weeks later. Lead I remains essentially the same except that there is slightly more ST depression, and the T wave may be slightly smaller. The P waves in Lead II are now more peaked. The QRS complex in both shows a small R although slurred; the ST now is biphasic in this lead. In lead III the Q is present, the R is more prominent, and the T is inverted. Lead aV1 remains essentially the same. Again I call your attention to V1, V2, V4, and possibly V6, showing the tall upright QRS in V1 with the R becoming smaller and the S wave deeper. This is exactly opposite to what one would expect to find in a normal heart or in a heart that has a myocardial infarction.

On this basis I am willing to ascribe the diagnosis of posterior wall myocardial infarction that Doctor Haukohl put into the record as a red herring for purposes of discussion, and interpret these electrocardiograms as demonstrable of right ventricular hypertrophy, right ventricular strain, or right ventricular preponderance.

With this interpretation the scope of the differential diagnosis immediately is reduced to three major categories; namely, mitral stenosis with right ventricular hypertrophy and right heart failure; congenital heart disease with a shunting defect or structural defect; and chronic cor pulmonale.

I believe mitral stenosis can be quickly ruled out by the absence of the rheumatic fever history and the absence of the presystolic or mid-diastolic murmur, but particularly on the strength of the clearness of the lung fields behind the mitral valve in the presence of congestive heart failure.

An atrial and or ventricular septal defect causing cyanosis, polycythemia, right heart strain, and congestive failure is possible, but again very unlikely in the presence of clear lung fields. These lesions are characterized by increased pulmonary vascularity. Isolated pulmonary stenosis would very nicely account for the right ventricular hypertrophy and the clear lung fields but fails to explain the symptoms of chronic hypoxia; namely, cyanosis, polycythemia, and the marked orthopnea and dyspnea.

Of the garden variety of congenital defects only tetralogy of Fallot or trilogy of Fallot would account for the right ventricular hypertrophy, the cyanosis, polycythemia, and clear lung fields. That is because of the combined lesion of pulmonary stenosis with a septal defect or overriding aorta. These two considerations are going to be more difficult to rule out, so I should like to hold them in abeyance for the time being.

The third category referred to previously is that of chronic cor pulmonale. This form of heart disease infers primary disease in the lungs, either as a result of defective pulmonary parenchyma or disease of the pulmonary vascular system. Primary lung disease may be quickly ruled out on the clinical and roentgen data. However, disease of the pulmonary vascular tree definitely is not ruled out.

So the diagnosis then simmers down to either congenital pulmonary stenosis with a right to left shunt such as in tetralogy of Fallot or pulmonary stenosis with an interatrial septal defect in order to explain the cyanosis, or primary pulmonary vascular

disease such as arteriosclerosis. The final separation must be made with the use of conjecture, speculation, statistics, and minutia involving certain aspects of cardiopulmonary physiology.

First, against the diagnosis of the congenital defect is the age group; although these patients are known to survive to the age of 53, this is an unusual occurrence. Second, the palpable thrills of pulmonary stenosis and the clubbing of fingers in right to left shunt are absent. Third, the cyanosis is apparently of recent duration on the basis of the history. But an important feature of these lesions is that oxygen does not relieve cyanosis.

Thus, we are left with a diagnosis of primary pulmonary vascular disease. The question arises as to whether this diagnosis can be made to hold with a critical analysis of the clinical, laboratory, radiographic, and electrocardiographic features of the case. Clinically, the symptoms and signs fit very nicely. The common age group is 45 to 55, although such disease has occurred with some frequency in younger people.

As in this case, the dyspnea is out of proportion to the amount of pulmonary congestion detectable either clinically or radiologically, contrary to what the lung findings are in left heart failure. In fact, the dyspnea of left heart failure is frequently relieved when the right heart fails. The cyanosis which frequently is associated with this lesion is probably on the basis of hypoxia due to a defect in the diffusion of oxygen across the alveolar capillary membrane secondary to probable sclerosis extending from the arteriolar side. Giving these patients oxygen, particularly if under pressure, will relieve the cyanosis, at least to a considerable extent, whereas in congenital right to left shunt the oxygen obviously can do nothing. The polycythemia is only another manifestation of chronic hypoxia in this particular instance.

The other features common to primary pulmonary vascular disease such as in arteriolosclerosis are as mentioned above: clear lung fields—and this is of very definite importance, the polycythemia, the right ventricular hypertrophy, and the refractoriness to digitalization.

Of course, the patient died primarily of congestive heart failure—particularly failure of the right ventricle; and I believe he developed a tricuspid insufficiency with dilatation and incompetence of the tricuspid ring and valves, thus giving rise to the systolic murmur described in the protocol. How much the considerable digitalization and mercurial diuresis with possible electrolyte imbalance contributed to the final demise will never be known, but all these situations may finally have been responsible.

In summary, therefore, this 53-year-old man had cyanosis with all the symptoms of right ventricular failure and was markedly dyspneic and orthopneic in spite of relatively clear lung fields as demonstrated clinically and radiologically. His electrocardiograms demonstrated a right ventricular hypertrophy rather than, in my opinion, a posterior wall myocardial infarct. These findings and the course of events in the hospital can best be explained on the basis of primary vascular disease of the lungs.

Questions:

Dr. C. A. Faber: You spoke of a primary vascular disease of the lung. Would you amplify on this—do you mean arteriosclerosis?

Doctor Sennett: Primary vascular disease of the lungs implies a disease process involving the small arteries, the arterioles, or sometimes the capillaries. The exact morphologic nature of the process cannot be determined clinically. The process might be a collagen disease such as scleroderma and periarteritis nodosa or arteriolosclerosis or atherosclerosis—anything that will affect the smaller vessels of the lungs. All I can do is pinpoint the site of the lesion; the rest is up to the pathologist.

Dr. J. A. Means: I would like to throw a little red herring into the diagnosis of pulmonary arteriolar disease or pulmonary arteriosclerosis. What is the cause of arteriosclerosis of the pulmonary tree? How does it begin and what causes it to develop?

We know that in arteriosclerosis you do need a certain amount of pressure in order for lipid molecules to pass into the vessel wall. This has been shown by Doctors Evans and Zeit at Marquette. If we are calling this a primary arteriosclerosis of the lung, or the so-called Ayerza's disease, how did the patient get his increased pulmonary pressure to begin with? He had to have that before he would have the hardening of the arteries of the lung. One thing that has been mentioned several times in the development of Ayerza's disease is the occurrence of multiple small

pulmonary emboli. This would cause spasm and at least temporary pulmonary hypertension. With pulmonary emboli one would like to hear that the patient manifested hemoptysis, which was apparently not present here; but this patient did complain of chest pain. He had had periodic chest pain for the last year with dyspnea and definite evidence of pulmonary vascular disease. But rather than accept primary pulmonary arteriolar sclerosis, we should think of the reason for an increase in pulmonary vascular pressure preceding the development of arteriolar sclerosis. I would like to propose the diagnosis of multiple small pulmonary emboli from the prostatic plexus or possibly the legs, causing hyalinization and the changes in the vessels of the lung and increasing the pulmonary pressure to the point where atherosclerosis of the lung could develop. Pathologically, unless this situation is caught in its actual happening the small pulmonary emboli will not be found. There was no evidence of pulmonary emboli on x-ray, but this is quite common. One must demonstrate them when they occur. We may have an area of increased density present one day and absent the next. To repeat I would like, therefore, to propose multiple small pulmonary emboli as a possible cause of the Ayerza-like condition presented by this patient.

Dr. Paul Jahn: I wonder if this man really had polycythemia or any evidence of chronic pulmonary disease. The process might well have been an acute one. You will notice that all elements of the peripheral blood are elevated including hemoglobin and red and white blood cells. He may have been dehydrated when the tests were done. Otherwise I wonder if that little nodule in the lung was a red herring, if anybody heard a murmur over it such as might be found with an arteriovenous aneurysm. However, I think this picture suggests something rather acute instead.

Doctor Sennett: These things, of course, went through my mind; and I was very much interested in the size of these pulmonary arteries because it may be of some importance. In our experience with congenital pulmonary stenosis at the Variety Club Heart Center, an experience involving something better than 60 to 70 cases, and a series of cases that was reported at the American College of Physicians, the breakdown revealed that several different situations may be present. In some cases of pulmonary stenosis there may be post-stenotic dilatation of the pulmonary arteries demonstrable by x-ray; and when you see this, all is well. But in about 40 to 50% of the cases there is no post-stenotic dilatation, so we have to throw that out as a guide in arriving at a diagnosis in this type of case. Secondly, I believe that this patient had right ventricular hypertrophy. There is no question about it; the electrocardiogram speaks for that. However, it is my contention that he also had pulmonary hypertension. Doctor Means' remarks are perfectly valid with one exception. In my opinion, one need not necessarily always have hypertension to cause arteriolosclerosis. It has been quite well demonstrated that increased flow in itself may cause arteriolar-like or sclerotic-like changes in the capillaries and in the arterioles. For example, consider an individual with a I-A septal defect or patent ductus arteriosus where, instead of the normal cardiac output, 4 liters per minute, there is an output of 12, 15, 16, or 20 liters per minute. With that tremendous difference in flow of blood across the vessels, particularly when there may be an element of hypoxia, one may see sclerotic changes in the small vessels. We know there is no correlation between pressure and flow. They follow similar curves but there is no true relationship, so increased flow itself may cause changes in the small vessels. Although I feel that this patient had pulmonary hypertension, I know that he had right ventricular hypertension; but I cannot tell you why he developed disease of his vessels. That is why I prefer to call it primary—I don't know the cause.

Necropsy Findings

Dr. Robert S. Haukohl, Pathologist: At autopsy this patient presented a rather interesting and unusual picture. He showed marked evidence of congestive heart failure. There was about 2,000 cc. of fluid in the abdomen. The liver and spleen were enlarged and markedly congested. Both pleural cavities contained 100 to 200 cc. of fluid but were partially obliterated by some fibrous bands, evidence of which you have seen in at least one of the chest films. The pericardial sac, too, contained an increased amount of clear yellowish fluid. The surfaces here were smooth and glistening. The heart, when

viewed within the body, appeared to be rather markedly enlarged. The anterior surface consisted almost entirely of massively hypertrophied and dilated right ventricle. The anterior surface of the heart was incised *in situ*, and an attempt was made to pass a finger into the pulmonary-vascular tree. Although the main pulmonary artery was of normal caliber and one could get a finger tip into the right pulmonary artery, it was impossible to get even the tip of the little finger into the left pulmonary artery. The thoracic viscera, therefore, were removed *en bloc* and the pulmonary-vascular tree dissected in continuity. This dissection covered a period of several days so that photographs could be taken of the various stages.

Examination of the heart showed massive hypertrophy of the right ventricular wall (fig. 1), which reached almost the thickness of a normal left ventricular wall. The pulmonary valve orifice, however, was of normal

Fig. 1—Photograph of opened right heart and pulmonary artery. The right ventricle is markedly hypertrophied, and the pulmonic valve is normal. The left pulmonary artery is markedly narrowed.

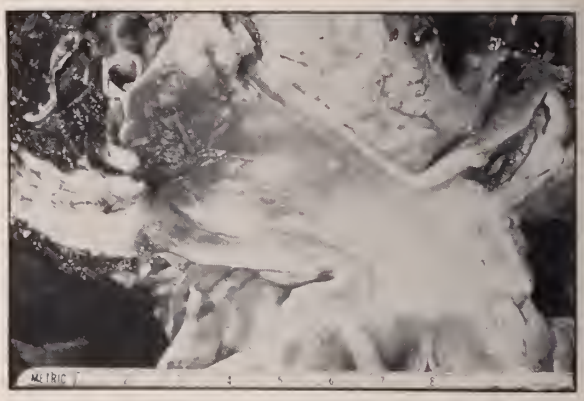


Fig. 2—Photograph of the opened pulmonary arteries. The narrowed left pulmonary artery and the principal branches of the right pulmonary artery are occluded by masses of soft thrombotic material and cholesterol debris.

circumference and the valve leaflets thin, pliable, and translucent. The pulmonary artery was of normal circumference to the point of bifurcation. Here marked narrowing of the left pulmonary artery was noted (fig. 1).

A little bit further on the left, the pulmonary artery was completely occluded by a mass of soft thrombotic material apparently consisting mostly of cholesterol crystals (fig. 2). A similar but less abundant amount of material was found in the right pulmonary artery. On both sides numerous atherosclerotic plaques appreciably narrowed the lumina of the primary and secondary branches of the pulmonary arterial tree. Microscopic sections showed the marked hypertrophy of the right ventricular musculature. The pathologic process in the pulmonary arterial tree consisted entirely of atherosclerosis with thickened, frequently hyalinized intima and marked accumulation of large foamy macrophages and numerous cholesterol crystals in the intima and media (fig. 3). In some of the smaller vessels massive hyaline thickening (fig. 4) was prominent with superimposed thrombosis. In some of the sections it was possible to show rather markedly hypertrophied and dilated bronchial arteries.

In summary, then, this case is one of marked primary pulmonary arteriosclerosis with terminal thrombotic occlusion of the left pulmonary artery. This latter finding would explain the more or less acute terminal episode. The chronicity of the process is attested to by the marked right ventricular hypertrophy, or cor pulmonale, and evi-

Fig 3 — Photomicrograph of an atherosclerotic plaque in one of the larger branches of the pulmonary artery.

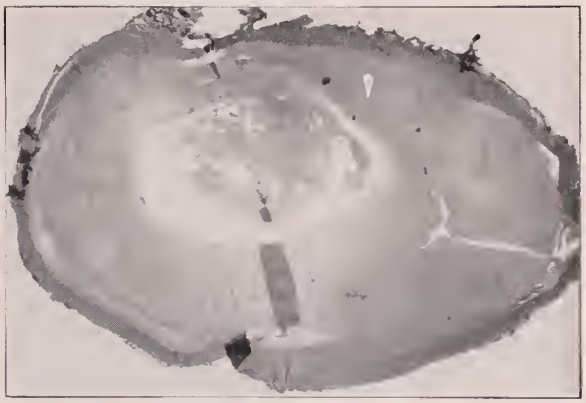


Fig. 4—Photomicrograph showing marked hyaline intimal thickening of a medium-sized pulmonary artery.

dences of chronic passive congestion in the liver and spleen, ascites, and dependent edema.

Pulmonary arteriosclerosis actually is not an extremely rare condition. Primary disease of this extent, of course, is. But in almost any individual of 40 years or more we see some evidence of arteriosclerosis in the pulmonary vessels, just as we see it in the systemic vessels. I do not believe that the frequent flat, yellow atherosclerotic plaques in the pulmonary vessels necessarily stand as a monument to pulmonary hypertension because they are so frequently seen in patients dying of entirely extraneous causes. Of course, more marked pulmonary arteriosclerosis may result in conditions in which pulmonary hypertension is prominent. This, of course, is associated with right ventricular hypertrophy and the formation of the so-called cor pulmonale. The best example of this condition is mitral stenosis. Much less commonly, the situation may occur with aortic valvular disease. The best examples of cor pulmonale are seen in pneumoconiosis on the basis of silicosis. Although disputed by some, the condition is alleged to occur in chronic pulmonary emphysema, in deformities of the thorax such as kyphoscoliosis, and in idiopathic pulmonary fibrosis with some obliteration of the vascular tree.

Primary pulmonary arteriosclerosis as a cause of hypertension and cor pulmonale is much less common. Inflammatory diseases of the pulmonary vessels, such as endarteritis obliterans, primary syphilitic arteritis, periarteritis nodosa, etc., are even more rarely see. Doctor Means brought up the name of Ayerza in connection with this entity. It would probably be best if we forgot all about this eponym. Ayerza was a physician from Buenos Aires who years ago—in 1901, I believe—described a cardiac patient with marked congestive failure and marked cyanosis. He referred to this condition as the "black cardiac." Unfortunately, in this case no one even studied the pulmonary vascular tree so that we have no assurance that there was a primary pulmonary vascular lesion. The name of Ayerza, however, has crept into the literature and is now surrounded by considerable confusion. Some feel that the eponym should be reserved for primary syphilis of the pulmonary arteries. Others feel that any massively cyanotic individual dying with cor pulmonale should be said to have Ayerza's disease. Actually, there is little agreement and we might best forget about the use of the term. Doctor Means further suggested multiple small pulmonary emboli at some time in the distant past. I'm afraid that I can't rule this possibility out entirely. Many of the small arteries might well have been initially occluded by emboli. However, if that were the case, I would expect to see in some of these vessels evidence of old hemorrhage in the form of hemosiderin-laden macrophages. This I did not find. The changes were primarily those of degeneration in the intima with the building up of thrombotic material into the lumen and some attempt at recanalization. I therefore felt that the disease process was best classified as primary pulmonary arteriosclerosis. Finally, I would like to compliment Doctor Sennett on his scholarly solution of this most difficult case.

The Effectiveness of Salk Vaccine in Wisconsin

As It Looks to Your State Board of Health

DUE to the use of poliomyelitis vaccine on the largest scale ever, the course of epidemic poliomyelitis this past summer was of more than usual interest and importance to all epidemiologists, immunologists, and clinicians. The program was of such proportions that measures of vaccine effectiveness and previous poliomyelitis epidemic patterns of incidence in time, as well as the age-group distribution of cases, might be altered.

The ensuing shortage of vaccine supply was not without some advantages; the original effective dosage schedule being an arbitrary one, it now became possible to measure the effectiveness of a single injection of vaccine against that of two or more injections in the prevention of disease. It appears that the State of Wisconsin, with the highest epidemic rate in its history and one of the highest in the country in 1955, will contribute much in this respect.

The information presented on this page is based on tentative preliminary data and will be subject to subsequent modification.

The incidence of paralytic and non-paralytic polio among vaccinates and non-vaccinates is shown in Table 1. In 87,763 children who had received at least one injection by July 31, 1955, the paralytic rate was 22.8 per 100,000 as compared with 101.7 in non-vaccinates; the non-paralytic rates were 50.1 in vaccinates as compared with 83.4 in non-vaccinates. This represents an effectiveness of 77 per cent in preventing paralytic polio and about 40 per cent in the prevention of non-paralytic disease. This is independent of the number of injections received by each child.

If one considers the effectiveness of one vs. two injections (Table 2), it becomes apparent that the rate among those who received two injections is about one-half that of those with single injections in respect to paralytic polio (a rate of 15.8 compared with 29.2). Two injections may be said to be 84% effective as compared with the 71% effectiveness of a single injection when results of both are compared with those in the non-vaccinated group (Table 3).

Rates show about a 40% decrease in non-paralytic poliomyelitis among vaccinates, being 18% lower among those receiving single injections and 54% lower in those receiving two or more injections than in non-vaccinates.

TABLE 1—*Wisconsin Poliomyelitis Rates (1955) Among Vaccinates and Non-Vaccinates*

PRELIMINARY DATA

Age Group	Estimated 1955 Population	No. of Children Receiving Vaccinations by 7/31/55	Cases in Vaccinates			Cases in Non-Vaccinates			Rates/100,000			
									Paralytic		Non-Paralytic	
			Paralytic	Non-Paralytic	Total	Paralytic	Non-Paralytic	Total	Vaccinates	Non-Vaccinates	Vaccinates	Non-Vaccinates
5 through 10	371,945	87,763	20	44	64	289	237	526	22.8	101.7	50.1	83.4

TABLE 2—*Wisconsin 1955 Poliomyelitis Rates Among Children with One Injection and Two Injections*

PRELIMINARY DATA*

Children	One Injection Only (7/31/55)						Children	Two Injections (7/31/55)					
	Cases			Rates				Cases			Rates		
	Paralytic	Non-Paralytic	Total	Paralytic	Non-Paralytic	Total		Paralytic	Non-Paralytic	Total	Paralytic	Non-Paralytic	Total
30,784	9	21	30	29.2	68.2	97.4	56,979	9	22	31	15.8	38.6	54.4

* Excludes 3 cases vaccinated in 1954 with "booster" in 1955.

TABLE 3—*Effectiveness of Poliomyelitis Vaccine*

	Rates		
	Paralytic	Non-Paralytic	Total
Non-Vaccinates	101.7	83.4	185.1
Vaccinates	22.8	50.1	72.9
Single Injection	29.2	68.2	97.4
Two or More Injections	15.8	38.6	54.4

To further evaluate the effectiveness of poliomyelitis vaccine, the State Board of Health is planning to study the extent of paralysis in vaccinates based upon muscle evaluation tests. It is expected that the physicians of these patients will be anxious to cooperate. —MILTON FEIG, M. D., *Director, Section on Preventable Diseases.*

MIDWEST REGIONAL MEETING, INTERNATIONAL COLLEGE OF SURGEONS, MADISON, WISCONSIN, APRIL 26–28, 1956

Thursday, April 26

3:00–7:30 p.m.—Registration—Loraine Hotel lobby
7:00 p.m.—Cocktails and dinner—Crystal Ballroom, Loraine Hotel (informal). For officers, regents, members and their wives
8:30 p.m.—Program
Dr. Ross T. McIntyre, Executive Director, International College of Surgeons
Dr. Geo. Callahan, Waukegan, Illinois—Illustrated talk on Far East

Friday, April 27

8:00 a.m.—Registration—Loraine Hotel lobby
8:30 a.m.—Welcome—Dr. A. S. Jackson, Madison
8:40 a.m.—Panel—"The Acute Surgical Abdomen"—Moderator—Dr. R. M. Kurten, Racine
9:30 a.m.—"Pancreatic Tumors"—Dr. C. E. Moore, Harrisburg, Pennsylvania
9:50 a.m.—Intermission
10:00 a.m.—Panel—"Gastrointestinal Hemorrhage"—Moderator—Dr. P. A. Rosi, Chicago
10:45 a.m.—Panel—"Biliary Surgery"—Moderator—Dr. R. R. Coffey, Kansas City, Missouri
11:00 a.m.—"Surgical Treatment of Breast Carcinoma"—Dr. L. P. River, Oak Park, Illinois
11:20 a.m.—Panel—"Problems of Thyroid Surgery"—Moderator—Dr. A. S. Jackson, Madison
12:10 p.m.—Adjourn
12:30 p.m.—Luncheon—Main Floor Dining Room, Loraine Hotel—Dr. R. M. Kurten, Racine, presiding
1:30 p.m.—Panel—"Problems in Herniorrhaphy"—Moderators—Dr. R. W. McNealy, Chicago; Dr. C. E. Moore, Harrisburg, Pennsylvania
2:20 p.m.—"Proctological Problems in Gynecological Patients"—Dr. G. F. Douglas, Birmingham, Alabama
2:40 p.m.—Panel—"Colon Surgery Problems"—Moderator—Dr. H. E. Bacon, Philadelphia
3:30 p.m.—"Planning Incisions for Breast Surgery"—Dr. R. R. Coffey, Kansas City, Missouri
4:00 p.m.—Intermission
4:10 p.m.—"The Use of Tantalum Mesh in Herniorrhaphy"—Dr. C. C. Guy, Chicago
4:30 p.m.—"Ulcerative Colitis"—Dr. H. E. Bacon, Philadelphia
5:00 p.m.—Adjourn
5:15 p.m.—Tour of Jackson Clinic
6:30 p.m.—Social Hour—Crystal Ballroom, Loraine Hotel (formal optional)
7:30 p.m.—Dinner
8:00 p.m.—Program
The Mozart Glee Club
European Trips of the International College of Surgeons, Dr. A. S. Jackson, Madison

Saturday, April 28

8:30 a.m.—Panel—"Urolithiasis"—Moderator—Dr. G. J. Thompson, Rochester, Minnesota
9:15 a.m.—Panel—"Surgical Problems in Gastro-Duodenal Ulcer"—Moderator—Dr. K. A. Meyer, Chicago
10:00 a.m.—"Management of Patients with Diverticular Disease"—Dr. Curtice Rosser, Dallas, Texas
10:20 a.m.—Intermission
10:30 a.m.—Panel—"The Management of Hip Fracture"—Moderator—Dr. E. L. Compere, Chicago
11:15 a.m.—"The Primary Repair of Traumatic Injuries of the Face"—Dr. Neal Owens, New Orleans
11:45 a.m.—"Surgical Treatment of Trigeminal Neuralgia"—Dr. C. S. MacCarty, Rochester, Minnesota
12:15 p.m.—Adjourn
12:30 p.m.—Luncheon
1:30 p.m.—"Indications for Prostatic Resection"—Dr. G. J. Thompson, Rochester, Minnesota
1:50 p.m.—"Intestino-Vesical Fistula"—Dr. G. H. Ewell, Madison
2:20 p.m.—"Plastic Surgical Repair of Urethral Stricture"—Dr. D. A. Culp, Iowa City, Iowa
2:40 p.m.—"Surgical Treatment of Hepatitis"—Dr. A. A. Strauss, Chicago
3:00 p.m.—Adjourn
3:05 p.m.—Bus tour of university and city

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A.F.L.–C.I.O. Says "Major Medical Expense Not the Answer"

Squeezed between the fundamentals of sound insurance and the high cost of completely comprehensive prepayment plans, the voluntary health insurance industry, including Blue Shield and private carriers, has about concluded that the health insurance movement has placed an undue emphasis on payment of the "first dollar" in health care. The administrative cost of insuring low-benefit, high-frequency items such as office calls and minor surgery is so high as to almost make prohibitive the development of sound programs for such expenses in health care.

Nevertheless, it is interesting for physicians to read the *Health and Welfare Newsletter* published for union officers and staff by the Labor Committee of the Cooperative Health Federation of America. In its February, 1956, issue, there was an article headlined "AFL–CIO Executive Council Says 'Major Medical Expense' Not the Answer." The full text of the article read as follows:

"Some commercial insurance companies have recommended major medical expense or catastrophic health insurance as a possible answer to the health needs of the American people. A number of unions have gained this type of coverage thru collective bargaining. Many employers and recently several government officials have endorsed major medical expense or catastrophic insurance.

"The *Newsletter* in previous issues has described what this type of health insurance provides and does not provide, what its disadvantages are and how they may be minimized by adding major medical expense or catastrophic coverage to a basic prepaid group health service plan which provides comprehensive--preventive and curative—health care.

"On February 6, the AFL–CIO Executive Council adopted the following broad and inclusive resolution on major medical expense insurance:

'The broader extension of 'major medical expense' or 'catastrophic' health insurance coverage, as has been advocated by some in government and industry, is neither a constructive basis for a national health program, nor an adequate answer to the need for comprehensive prepaid health services. Unless accompanied by measures designed to aid in the development and expansion of direct medical service prepayment programs which emphasize preventive care and encourage early diagnosis and treatment, any effort on the part of the government to promote the 'catastrophic' insurance policies of private carriers can only lead to further inflation of medical costs and deterioration in the quality of medical care, while ignoring the most essential health needs of the public.

'The type of 'major medical expense' or 'catastrophic' insurance policy presently offered by commercial carriers cannot be regarded as a suitable alternative to, or substitute for, a sound basic program of comprehensive insurance protection which provides for diagnosis and treatment in the home or doctor's office as well as in the hospital, and which covers the common as well as the exceptional condition. Where a satisfactory basic program of this type already exists, a 'major medical' insurance provision may be useful as a secondary supplement to such a program. The measure of its acceptability, however, should be the extent to which the basic health plan already meets the primary objective—to remove the dollar barrier to comprehensive health services, including preventive care, for the entire family."

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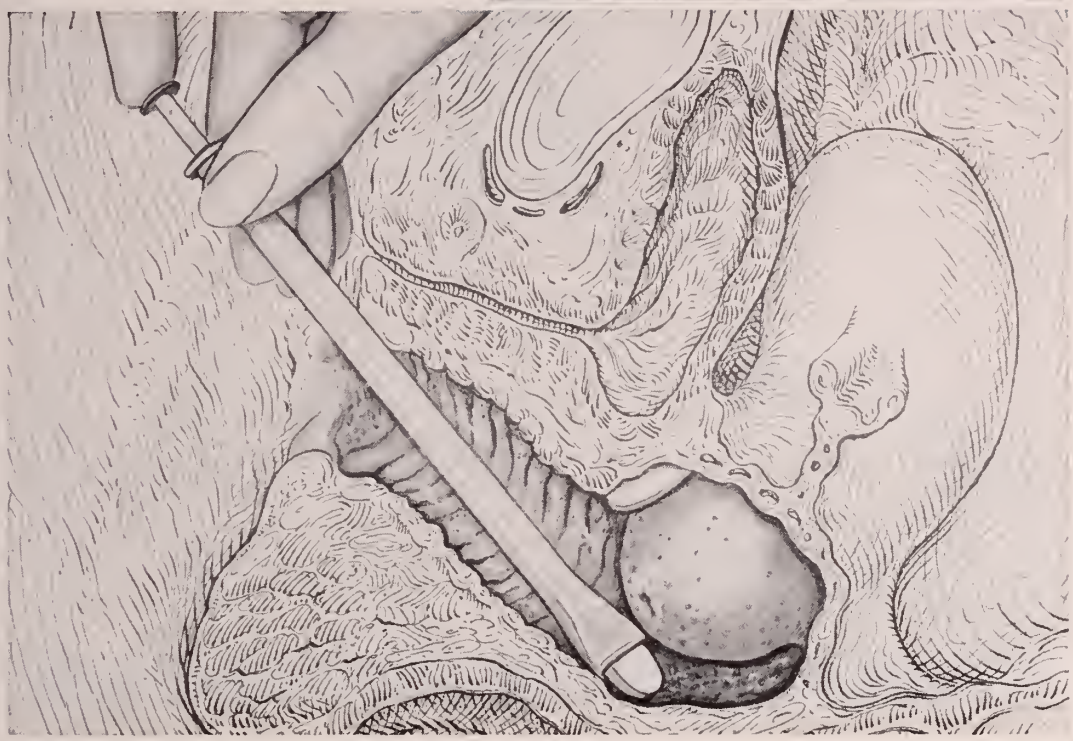

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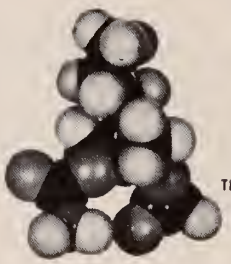

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"Cultists, Expediency, and Responsibility"

The doctors of the state of Georgia are to be commended for the part they played in getting the Georgia General Assembly to prohibit the pseudo-medical practice of a cult within the state which was a monumental step in the betterment of the public welfare and the protection of the citizens. The great majority of our profession know that cults exist but many of us are not cognizant that these cults can do a great deal of harm, and usually the harm is done to the uninformed people.

The following paragraphs have been taken from an editorial in the Georgia Medical Association Journal, and I think we in Wisconsin will find a great deal of meaning in them:

"Because of their training and insight in the healing arts, physicians were the logical leaders in such a campaign for public education. By utilizing their resources and achieving the almost unanimous repeal of that ill-advised licensing act, the doctors of Georgia have helped not only the man in the street, but have increased the stature and general prestige of the profession. Our prestige has been bolstered because of our awareness of an issue of public concern and our willingness to go to bat for a cause which we knew to be just.

"In our profession, we find ourselves in a peculiarly advantageous position to effect actions for the public good, if we could only bring ourselves to realize our responsibilities as citizens, not only in our individual communities, but in the state and nation as well. No single group of informed citizens is so free to speak out and to speak without fear of reprisal from opposing pressure groups. A doctor who practices good, honest medicine in a community where he is needed and whose conduct is that of a gentleman, is without peer as a person of influence. With the advantage of superior education, public respect, and influence, we must (whether we like it or not) accept the position of responsibility in which most of us find ourselves and speak out on public issues which we know to be vital. Rather than hurt ourselves and our profession, we can improve its standing and prestige immeasurably.

"What other group in this 'land of the free' is so immune to pressures? Almost daily we hear someone comment that we are all tied to our pocketbooks and that almost everyone sacrifices principle to expediency. The poor clerk must bow to his boss whatever the circumstances; the minister is in principle subservient only to God, but for the budget he may be forced to acquiesce to the wishes of the rich parishioner; the newspaper editor knows well to delete any news item that might put the owner or publisher in a poor light; the university or college

president, who pays lip service to academic freedom, in the final analysis often has to bow to the board of trustees, regents, football-crazed alumni, and so on down the line. This is meant as no condemnation of these people; it is one of the sad realities of life. There are many stout hearts in all walks of life who want desperately to speak out for what they know to be right but who out of fear for their jobs and their futures must remain silent.

"We are in a position to speak for these people as well as for ourselves. Let us not remain silent, for we shall not pass this way again."

A Valuable Program

There are several reasons for the existence of the State Medical Society of Wisconsin, but the most important is to advance the scientific attainments of its members so that they may better serve the citizens of Wisconsin.

The Council on Scientific Work is the committee of the State Medical Society that is charged with this responsibility, and it has prepared an outstanding program for the Annual Meeting, which will be held on May 1, 2 and 3 in Milwaukee. There should be many things to interest you and to inform you on this program. I'm sure they will be quickly apparent if you review the program on pages 397 to 425.

It will be to the interest of your patients that you attend this meeting and become further informed regarding the recent advances in scientific medicine.

There are, we all agree, too many medical meetings and one cannot attend them all; but this is one you should not miss. It is the meeting of your own state society. It is your meeting. We promise you a valuable program, and we hope to see you there.

S. A. Morton, M.D., *Chairman*
Council on Scientific Work

Up and Still Upward

"We must expect hospital costs to continue to increase about 5 per cent annually for many years." "The hospital must educate the public to the need for paying more for Blue Cross."

These related statements came from two speakers at the Wisconsin Hospital Association's annual meeting in Milwaukee on March 15. They should be enough to alert every physician and certainly should give pause to physicians, administrators, and laymen alike, for all must be concerned with the increasing cost of health care.

Ray Brown, president of the American Hospital Association, minced no words as he predicted a continued increase in hospital costs. The news came as a surprise to no one, although few are willing to speak about it. Mr. Brown added one fact, however, that should be noticed by everyone. He said that 64 per cent of all hospital costs are in pay roll and that pay roll costs per patient day rose at the rate of 165 per cent in the period from 1946 to 1954, while the consumer price index went up only 37.6 per cent in the same period.

Harry Becker, former U.A.W.–C.I.O. insurance advisor and now a program consultant to Blue Cross plans throughout the nation, pleaded with hospital administrators to get busy and educate the public to increase their allocations for hospital care. "To whatever extent hospitals fail in their efforts to make Blue Cross their financing arm, hospital finances will be, in the years immediately ahead, in jeopardy," Becker declared. Fearing that each new rate increase will impair the intangible factor of public willingness to buy, Mr. Becker put the finger on all hospitals to become salesmen for Blue Cross.

Interestingly enough, in light of recently growing physician awareness of the problem, Mr. Becker urged Blue Cross to extend benefits to include such items as out-patient visits and convalescent home care for services that can be provided more cheaply on an ambulatory basis.

The physician can well afford to heed these comments, for it is he whom the patient more than likely holds responsible for the total cost of his health care. From the standpoint of the patient, it is the doctor who directs his health care, including hospitalization; and it is not illogical, therefore, that he concludes that the doctor should be interested in his over-all welfare, including the financial aspects.

CONTINUATION COURSES AT UNIVERSITY OF MINNESOTA CENTER FOR CONTINUATION STUDY

Dates	*Name of Course*	*Guest Speaker*
May 7–12	Electrocardiography for General Physicians	Dr. Harold Levine Harvard University Medical School
May 14–19	Proctology for General Physicians	
May 24–26	Surgery for Surgeons	Dr. Robert M. Zollinger Ohio State University College of Medicine
June 4–6	Dermatology for General Physicians	

. . . . THE PRESIDENT'S PAGE . . . .

SPECIAL features of the 1956 Annual Meeting, May 1, 2, and 3, make it the best ever planned. I am sure that you will agree after looking over the preliminary program.

Special refresher courses, a General Practice Day, distinguished lecturers, a new members' luncheon, the tournament of the Wisconsin State Medical Golf Association (April 30), Gemütlichkeit night, and the annual dinner are some of the highlights. Of course, as usual, there will again be an excellent array of commercial and scientific papers, important business before the House of Delegates, and special activities for the ladies. This is an Annual Meeting you can't miss!

The General Practice Day will be Tuesday, May 1. The morning program will be divided into refresher courses to be followed by two scientific presentations. The afternoon program will include three papers and a tumor clinic.

Several of the specialty societies will hold meetings in conjunction with the three-day Annual Meeting. Members of these groups will be notified of the meetings.

For the first time there will be a special luncheon for new Medical Society members. Each of the nearly 200 new members (116 from Milwaukee!) will hear talks on medical-legal problems and related subjects.

And, of course, our annual tribute to those gentlemen in our profession who have reached the fifty-year mark in their practices will be made at the annual banquet on Thursday evening, May 3. Thirteen members will receive certificates making them members of the State Medical Society "Fifty Year Club."

Our officers and staff have worked diligently and eagerly to make this annual event one of the better meetings to be held in the nation. It's up to you to make it the most successful!

I also wish to express appreciation of the membership to the staff of the Medical Society of Milwaukee County for its assistance at all functions of our Annual Meeting.

Erwin L. Bernhart M. D.

Society Proceedings

Calumet

The Calumet County Medical Society met February 7 at the Old Mill in Hayton. Election of officers was held, resulting in the re-election of all who held office in 1955. *Dr. F. P. Larme,* New Holstein, continues as president, *Dr. Kenneth Humke,* Chilton, as secretary–treasurer.

The society, in a business meeting, voted its approval of the county polio vaccine program, details of which, it was decided, would be worked out when the vaccine was received.

Guest speakers at the meeting were: Mrs. Gladys Steaven, county nurse, and I. J. Shyne, administrator of Calumet Memorial Hospital.

Jefferson

Twenty-one members were present at the February 16 meeting of the Jefferson County Medical Society, which was held at the Meadow Springs Country Club, Jefferson. Guest speaker at the meeting was *Dr. H. H. Shapiro,* Madison, who chose as his topic, "Treatment of Hypertension."

In a business session which followed, it was decided that a public clinic will be held to administer the Jefferson County quota of the Salk polio vaccine.

Kenosha

The March meeting of the Kenosha County Medical Society was held at the Elks Club in Kenosha, and 46 members were in attendance.

The entire meeting consisted of a business session devoted to discussion of local matters.

Marinette–Florence

At the January, 1956, meeting of the Marinette-Florence County Medical Society, the following physicians were elected officers for 1956:

President—*R. J. Rogers,* Oconto
Vice-President—*John Bell,* Marinette
Secretary—*Kenneth Pinegar,* Marinette

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Outagamie

The February 29 meeting of the Outagamie County Medical Society was held at the Elks Club in Appleton. The meeting was devoted mainly to a cocktail party and dinner sponsored by the Chas. Pfizer Company of New York, and doctors from Brown–Kewaunee–Door, Outagamie, Waupaca, Winnebago, Calumet, Fond du Lac, Sheboygan, and Manitowoc medical societies attended, bringing the total number present to 110.

Mr. J. E. Boron, a hypnotist, provided the entertainment for the meeting.

Pierce–St. Croix

The regular monthly meeting of the Pierce–St. Croix County Medical Society was held February 21 at Glenwood City.

Election of officers was held, and the following now preside: president, *Frank Springer,* Elmwood; secretary, *P. H. Gutzler,* River Falls; delegate, *P. H. Gutzler;* and alternate delegate, *O. H. Epley,* New Richmond.

Sauk

Nineteen members of the Sauk County Medical Society were present at the February 14 meeting held at the Warren Hotel in Baraboo. Guest speaker at the meeting was *Dr. Robert Burns,* professor of orthopedic surgery at the University of Wisconsin Medical School. Doctor Burns spoke on the recent advances in hip and knee joint surgery.

In the business session of the meeting, it was decided that the society would cooperate with the health department in holding a free clinic for the giving of Salk vaccine to the first and fourth grade children.

Trempealeau–Jackson–Buffalo

The February 28 meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held at the Club Midway in Galesville.

Guest speakers at the meeting were representatives from the county welfare departments of each county and Mr. Casey, district supervisor of the State Department of Public Welfare.

Winnebago

The Winnebago County Medical Society met March 1 at the Elks Club in Appleton. Guest speakers at the meeting were Drs. *Leon Hirsh* and Phillip Feingold, both professors at Marquette University School of Medicine. Doctors Hirsh and Feingold spoke on "Pulmonary Fungus Disease and Diagnosis, and Treatment of Pulmonary Hemorrhage."

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Wood

New officers were elected at the February 9 meeting of the Wood County Medical Society held at the Hotel Charles, Marshfield. They include: *Dr. E. C. Glenn*, Wisconsin Rapids, president; *Dr. J. M. Wickham*, Marshfield, vice-president; *Dr. N. J. Helland*, Marshfield, secretary; *Dr. R. W. Mason*, Marshfield, delegate; and *Dr. H. G. Pomainville*, Wisconsin Rapids, alternate delegate.

American Academy of General Practice

Milwaukee Chapter

At a recent meeting of the Milwaukee Chapter of the American Academy of General Practice, election of officers was held, and the following now preside:

President—*A. J. Sanfelippo*
Secretary—*W. C. Fetherston*
Treasurer—*W. J. Conen*
Delegates—*R. E. Callen* and *L. E. Rothman*
Alternates—*M. B. Byrnes*, *A. A. Presti* and *E. P. Bickler*

Wisconsin Dermatological Society

The Wisconsin Dermatological Society held its winter clinical meeting at the Milwaukee Children's Hospital on Saturday, March 3. Thirty dermatologists were present, including guests from Rochester, Minnesota; Ann Arbor, Michigan; and Chicago, Illinois. Twenty-four patients with skin diseases were presented, and their conditions were discussed by the members.

Election of officers was held for 1956, and the following now hold office: president, *Dr. H. J. Farrell*, Milwaukee; vice-president, *Dr. L. S. Markson*, Milwaukee; and secretary, *Dr. D. M. Ruch*, Milwaukee.

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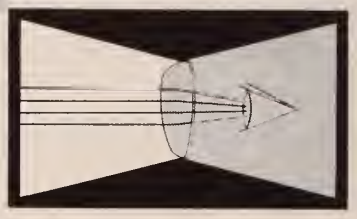

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News Items and Personals

Dr. George Hathaway Moves to Las Vegas

Dr. George Hathaway, formerly chief surgeon of the Grand Army Home for Veterans at King, has relocated in New Mexico, where he will assume the position of superintendent of two state-owned hospitals.

Doctor Hathaway's duties at King will be assumed by Dr. James E. Murphy. Doctor Murphy has served on the staff of the Winnebago State Hospital at Winnebago since 1949, and prior to that time practiced medicine in the Clintonville area for several years.

Physicians Speak at School Health Conference

Speakers at a school health conference held on April 12 in Platteville were *Dr. E. S. Gordon* of the University of Wisconsin, who spoke on "The Integrated Physical and Emotional Growth of Children," and *Dr. E. H. Pawsat,* Fond du Lac, chairman of the State Medical Society's Division on School Health. The conference was sponsored by the State Medical Society and the State School Health Council in conjunction with a number of other state and local agencies.

A luncheon was held at the college, after which a film entitled "School Health in Action" was presented. Small group sessions followed, and there were discussions on Health Examinations of Pupils and School Personnel, Special Health Problems, Health Aspects of Physical Education, Putting Preventive Mental Health Concepts to Work in Schools, and Referral and Treatment of Pupils with Emotional Problems.

Oconto Women's Club Hears Doctor Zantow

Dr. F. E. Zantow, Oconto, addressed the Oconto Women's Club at its meeting on February 20. The subject of his talk was "Living With Your Heart." Two brief films on the subject of hearts were also shown. They were entitled "Take It Easy" and "Pump Trouble."

Staff Officers Named at Rice Lake Hospital

Dr. R. W. Adams, Chetek, was elected chief of staff of St. Joseph's Hospital in Rice Lake at the

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*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

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1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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regular February meeting of the hospital staff. Others elected were *Dr. W. F. Vaudreuil*, Rice Lake, vice chief of staff, and *Dr. A. C. Halberg*, Turtle Lake, secretary.

Doctor Lukasek Attends Medical Course

Dr. E. O. Lukasek, Sparta, attended a continuation course held at the University of Minnesota February 13 through 15. The course was on "Recent Advances in Internal Medicine."

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Ernst Schmidhofer to Enter Private Practice

Dr. Ernst Schmidhofer has resigned as director of the Milwaukee County Asylum to enter private practice in the specialty of psychiatry in Milwaukee. His resignation will become effective May 1.

Dr. G. P. Wyman was appointed to succeed Doctor Schmidhofer. Doctor Wyman is presently superintendent of the Central State Hospital at Lakeland, Kentucky.

Dr. Edmund Liebl Joins Monona Grove Clinic

Dr. Edmund Liebl, who has recently completed a year and a half of residency training in Milwaukee, has become associated with *Dr. Gerald Derus* in the general practice of medicine and surgery. Doctor Liebl joined the Monona Grove Clinic located in Madison in February.

He is a graduate of the University of Wisconsin Medical School and practiced medicine at the Dean Clinic, Madison, for a year after his internship was completed.

Madison Physicians Attend American College of Surgeons Meeting in Milwaukee

Six Madison surgeons, all professors at the University of Wisconsin Medical School, attended the sectional meeting of the American College of Surgeons held in Milwaukee February 27–29.

Those attending the meeting included *Drs. R. E. Campbell, A. R. Curreri, J. W. Gale, K. E. Lemmer, E. R. Schmidt*, and *Madeline J. Thornton.*

Beloit Hospital Staff Officers Named

Members of the Beloit Hospital staff elected new officers at the annual meeting held February 7.

Dr. R. S. Wilson, Beloit hospital radiologist, was named president of the staff. Doctor Wilson will succeed *Dr. W. L. Cochrane* in this post.

Other officers elected at the meeting were *Dr. T. C. Sweeney*, president elect, and *Dr. Frank Johnson*, secretary–treasurer. Named to the executive committee were *Drs. A. H. Twyman, C. G. McGaughey*, and *W. L. Cochrane.*

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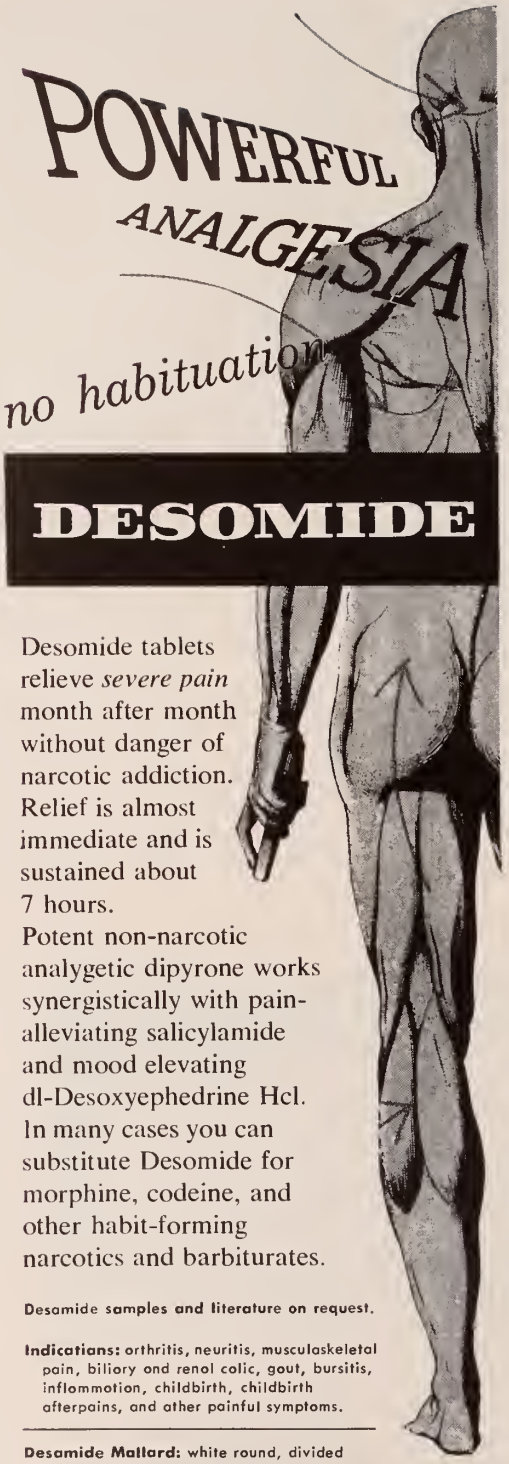

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Dr. J. A. Schindler Gives Talks

Dr. J. A. Schindler, Monroe, was the guest speaker March 11 at the Memorial Hall in Racine. Doctor Schindler, who is the author of *How to Bring Living Back to Life* and *How to Live 365 Days a Year*, was the third speaker in a series of four lectures being presented by the Racine Public Library.

He also recently addressed a convention of the National Association of Secondary School Principals held in Chicago. He pointed out that it was his belief that more effort should be made to teach children maturity. He stated that what a man becomes is entirely dependent upon the maturity he attains.

Speaking on March 8 at the Woman's Village Improvement Club meeting in Janesville, Doctor Schindler chose as his topic "Our Minds and Our Emotions."

Dr. R. E. Campbell Attends Meeting

Dr. R. E. Campbell, Madison, recently attended the district meeting of the American Academy of Obstetrics and Gynecology, which was held in Memphis, Tennessee. Doctor Campbell is national president of the organization.

Doctor Snodgrass Presides at Session of ACS Meeting

Dr. T. J. Snodgrass, Janesville, presided at one of the sessions of a three-day sectional meeting of the American College of Surgeons held in Milwaukee February 27 to 29. He conducted a panel dealing with "Surgery of the Spleen."

Other subjects discussed at the meeting were handling of mass casualties, fractures in children, heart surgery, cancer, intestinal obstruction, cataracts, thyroid gland, the spleen, and other surgical problems.

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Madison Kiwanis Club Hears Doctor Allin

Dr. Robin Allin, Madison, addressed the Madison Kiwanis Club at a noon luncheon held at the Park Hotel on February 20. His subject, "Let's Talk About Your Heart," gave five rules to follow in taking precaution against a heart attack. He also pointed out that it must be realized that, even though heart disease is the No. 1 cause of death, the reason is that people are living longer as a result of medical progress.

Doctor Rattunde Locates in Madison

Dr. Henry Rattunde recently joined *Dr. C. A. Fosmark* in the practice of general medicine and surgery in Madison.

He is a graduate of the University of Wisconsin Medical School, has served two years as a surgeon in the Air Force, and has spent three and a half years in residency in general surgery.

Doctor Steinkopff Locates in Ohio

Dr. E. K. Steinkopff recently resigned from the position of medical director of Pinehurst Sanatorium, Janesville, a position which he had held for the past 10 years.

He began his duties as superintendent and medical director of the District Tuberculosis Hospital at Lima, Ohio, on March 19.

Doctor Schweiger Restricts Practice to Treatment of Cardiovascular Diseases

Dr. L. R. Schweiger, Milwaukee, recently announced the restriction of his practice to cardiovascular diseases. He is certified by the American Board of Internal Medicine and the Subspecialty Board of Cardiovascular Diseases.

Conference Held on Problem Drinking

The "All Wisconsin Industry and Community Conference on Problem Drinking" was held March 1 at Marquette University.

Internationally recognized authorities in the fields of medicine, sociology, religion, and industry gave reports on tested and proved techniques for a realistic approach to problem drinking, which has become America's No. 4 public health problem.

Co-directors of the conference were *Dr. E. L. Belknap,* Marquette University School of Medicine faculty member, and Mr. M. R. Kilp, executive director of the Wisconsin Council of Alcoholism.

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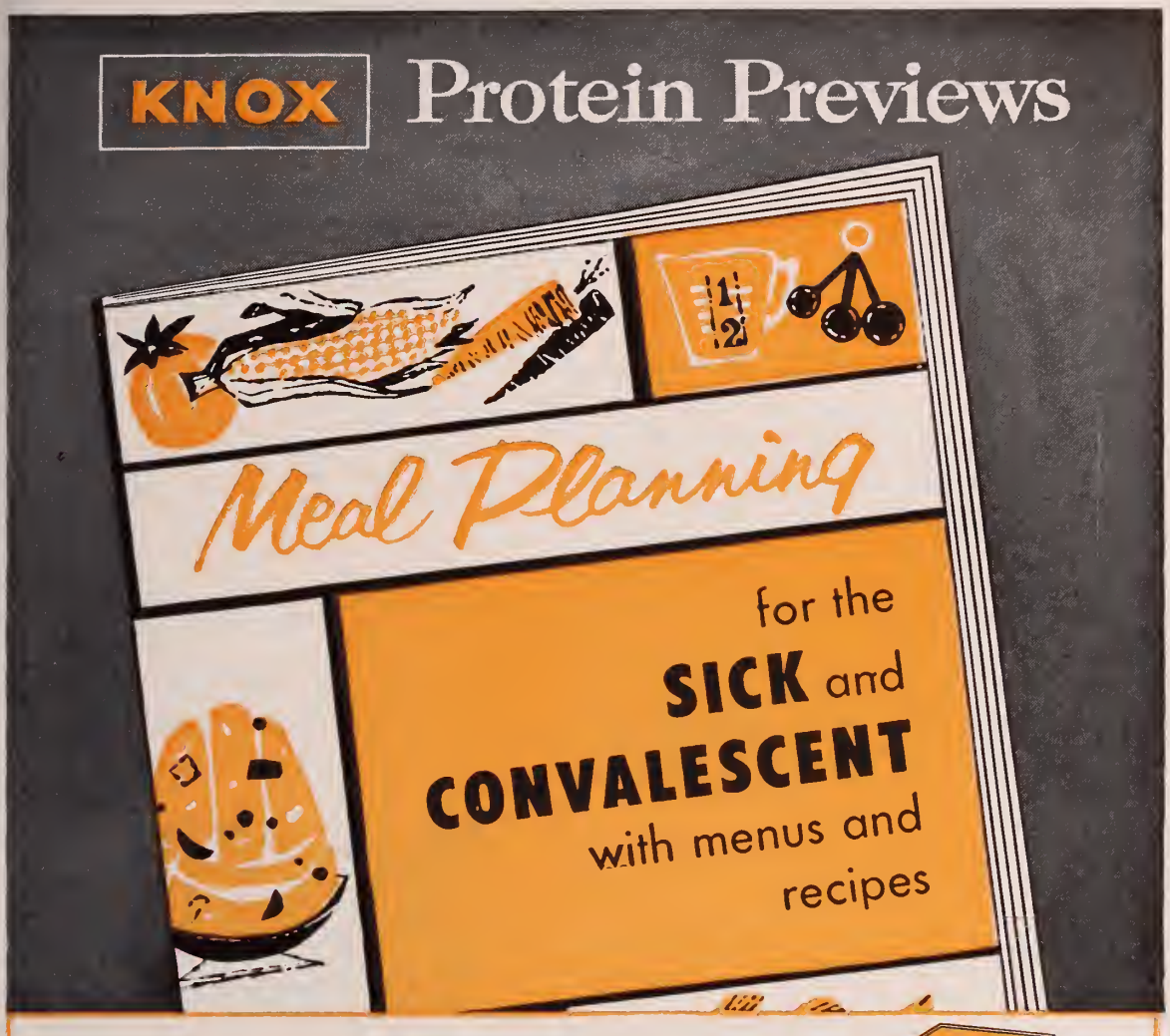

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G. H. Brannon, Winneconne.

R. L. Baker, 917 Church Street, Beloit.

K. W. Halgrimson, 613 Fulton Street, Eau Claire.

John Z. Bowers, 1300 University Avenue, Madison.

Manucher Javid, 1300 University Avenue, Madison.

Joyce C. Kline, 162 Proudfit Street, Madison.

H. F. Rattunde, 2901 Atwood Avenue, Madison.

Isadore Mallin, 7231 West Greenfield Avenue, West Allis.

M. R. Vrtilek, 1719 South 21st Street, Milwaukee.

G. R. Zupnik, 2947 North 67th Street, Milwaukee.

H. L. Davis, Monroe Clinic, Monroe.

J. A. Frantz, Monroe Clinic, Monroe.

Changes of Address

V. T. Davis, Madison, to 135 West Hanover Street, Trenton 25, New Jersey.

Harry E. Thimke, Iowa City, Iowa, to 603 Emery Street, Eau Claire.

J. F. Bennett, Oakland, California, to 610 Lee Avenue, San Leandro, California.

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OBITUARIES

Dr. J. H. Carroll, 72-year-old Burlington surgeon, passed away February 22.

Doctor Carroll was born in Milwaukee on July 4, 1883. He attended Marquette University School of Medicine and received his degree in 1911. He served his internship at St. Mary's Hospital in Milwaukee and had a general practice residency at St. Michael's Hospital, Milwaukee. From 1911 to 1944 he practiced medicine in Milwaukee. In 1944 he moved to Burlington, where he established general practice.

Doctor Carroll served as a lieutenant in the Army Medical Corps in 1918–1919.

He was a member of the Racine County Medical Society, the State Medical Society, and the American Medical Association. He served on the staff of the Burlington Memorial Hospital, and for the past eight years had been the health officer for Burlington.

Surviving him are his widow, Doris, Burlington, and one son, Dr. Paul; three grandchildren; and one sister, Anna, all of Milwaukee.

Dr. Thomas J. Budnick, East Troy physician, died February 23 as a result of injuries received in a natural gas explosion which occurred at his office.

Doctor Budnick, who was 31, was a native of Superior. He graduated from Marquette University School of Medicine in 1951, after which he interned at St. Mary's Hospital, Milwaukee. Prior to May, 1955, when he located in East Troy, Doctor Budnick had been in private practice at Waterford.

He was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Audrey; an 8-month-old son, Thomas, Jr.; his mother, Mrs. Ann Budnick, Milwaukee; and two sisters, Mrs. Ronald Jermstad, Washington, D. C., and Miss Sally Budnick, Milwaukee.

Dr. William F. Weingart, a retired Milwaukee physician, died on February 7, 1956. He was 82 years of age.

Born in Germany in 1873, Doctor Weingart came to the United States in 1901. He was graduated from Valparaiso University in Indiana, after which he spent three years at the Chicago College of Medicine and Surgery, where he received his medical degree in 1911. He interned at the Chicago House of Correction in 1912, and opened offices in Milwaukee in 1913 for general practice.

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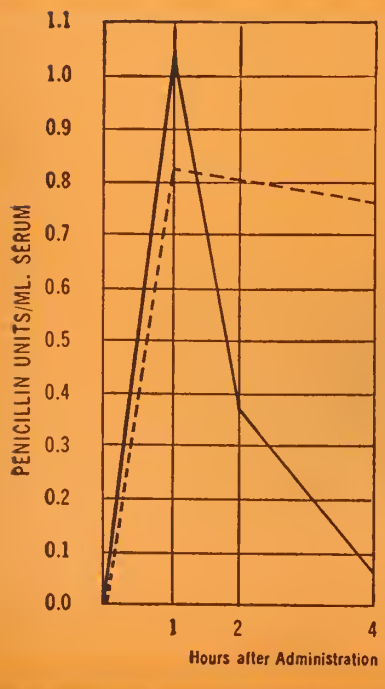

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He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

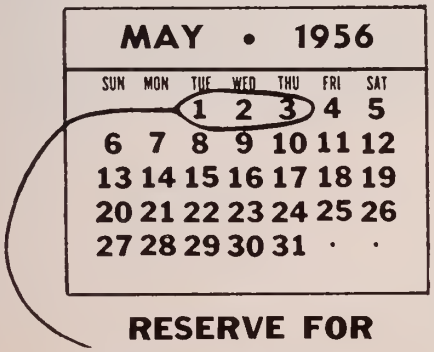
A son, William F., Jr., Milwaukee, survives.

Dr. Charles A. Squire, prominent Sheboygan physician and surgeon, died February 17 at the age of 81 years.

Doctor Squire was born in Sheboygan in 1875, and received a bachelor of science degree at the University of Wisconsin in 1898. He later enrolled at the Chicago Hahnemann School, where he received his medical degree. He served his internship at Cook County Hospital, Chicago. In 1907 he joined his father in general practice at Sheboygan. He was one of the founders of the Sheboygan Clinic and was on the staff of the clinic at the time of his death.

He held membership in the Sheboygan County Medical Society, and was a member of the Fifty Year Club of the State Medical Society of Wisconsin. He also was a member of the American Medical Association.

Surviving him are his wife, and a daughter, Susan, both of Sheboygan, and a sister, Mrs. Alice Gifford, Chicago.



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Electrocardiography & Heart Disease, Two Weeks Basic Course, July 9
Gastroscopy & Gastroenterology, Two Weeks, September 10
Dermatology, Two Weeks, May 7
RADIOLOGY—Diagnostic X-Ray, Two Weeks, April 30, September 17
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*Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, The Williams and Wilkins Company, 1954, p. 998.

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1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

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CORRESPONDENCE

Gentlemen:

We wish to express our appreciation for the booklets furnished to us by the State Medical Society. The information they contain is extremely useful and it's convenient to have it compiled into one volume.

Sincerely,
THE JUNIOR CLASS
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United States Senate
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Gentlemen:

I was pleased to see the commendation of the new pamphlet put out by the Better Business Bureau, as reported in your December 1955 issue.

This pamphlet, "Facts You Should Know About Health Cures," should, we all hope, serve to alert laymen so that they will not be deceived by quacks vending phony drugs, devices, cosmetics, and appliances.

As you know, from time to time, I have had occasion in the Senate to commend the efforts of the Food and Drug Administration in cracking down on charlatans. Since this year is the 50th anniversary of the Food and Drug Law, it is particularly appropriate to intensify efforts against the fakers.

I know that *The Wisconsin Medical Journal* will continue to render vital service, not only to the great medical profession of our state, but through them to our entire population, receiving ever better medical care.

With kindest wishes, I am

/s/ ALEXANDER WILEY

Gentlemen:

On behalf of the junior medical class at Marquette University I should like to thank you for the copies of *The Wisconsin Medical Journal* which you so kindly sent our members. I am certain that all my colleagues would wish to join me in this since the magazine was not only replete with items of great interest to us all but brought us in closer contact with our future profession.

Sincerely yours,
/s/ KRYSTYNA SKLENARZ
Secretary, Junior Class

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The Bells Are Ringing

In cities, towns and villages all over America, the ringing of church bells one day in April will mark the launching of the annual Cancer Crusade of the American Cancer Society. At the same time, in many doctors' offices, the staccato ring of door and telephone bells will mark the success of a major objective of the Society.

"Fight Cancer with a Checkup" is the American Cancer Society's immediate, short-range answer to the terrible toll of lives taken each year by this dread disease. It is to your office that the Society is urging the public to go for the periodic examinations that can mean the early detection and prompt treatment of cancer, and could prevent thousands and thousands of needless deaths.

Achievement of our ultimate goal — the conquest of cancer — will be largely determined by the response to our plea to "Fight Cancer with a Check". This year the Society needs $26,000,000 to carry on its vital program of education, research and service.

"Fight Cancer with a Checkup and a Check"—a winning combination. With your support and the cooperation of the public, the sound of victory will one day ring through the land.

American Cancer Society

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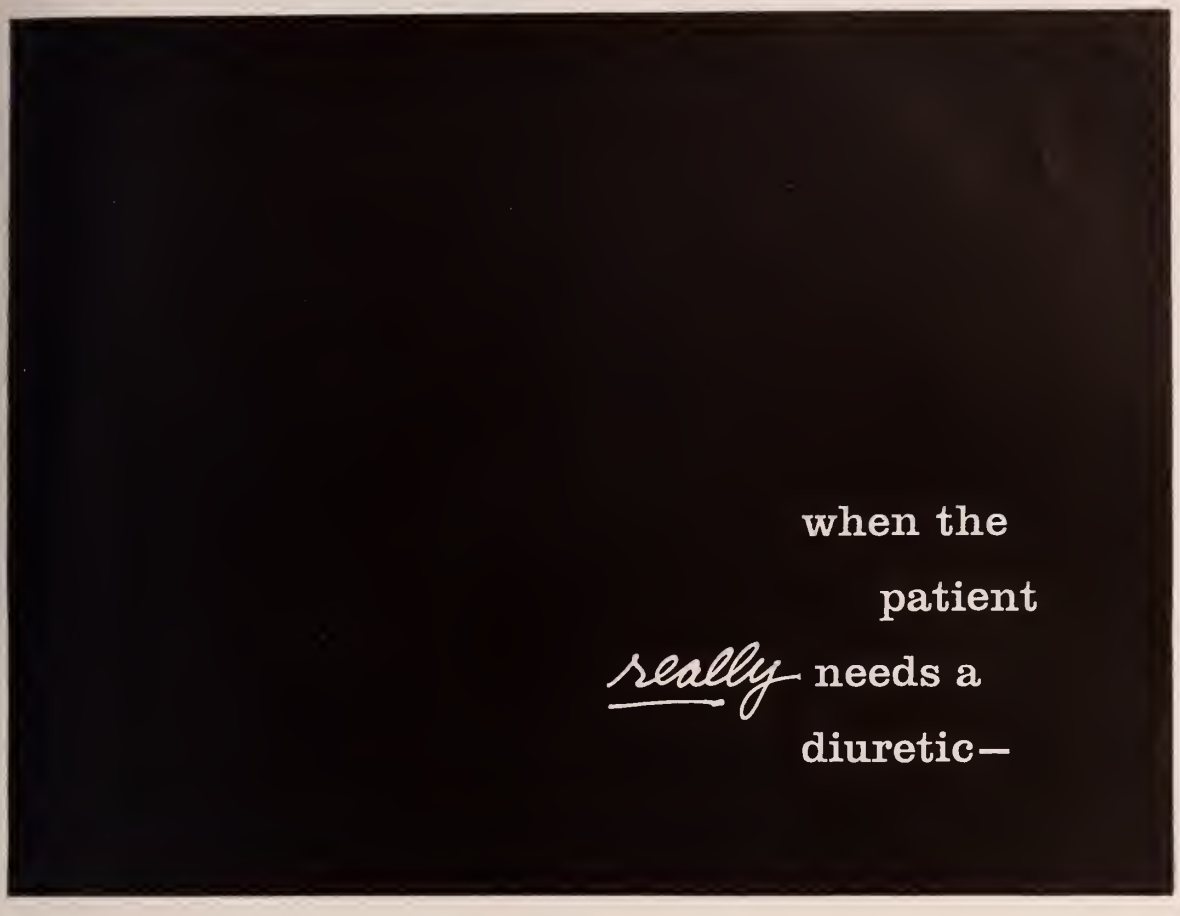

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INDEX TO ADVERTISERS

	Page
Ames Company, Inc.	377
Ayerst Laboratories	383
Barr X-Ray Company	376
Benson Optical Company	474
Brown and Williamson Tobacco Corp.	491
Burroughs Wellcome & Co., Inc.	382
Ciba Pharmaceutical Products	476
Coca-Cola Company	482
Cook County Graduate School of Medicine	487
Corn Products Company	371
Davies, Rose & Co., Ltd.	481
Doerflinger Artificial Limb Co.	494
Endocrine Laboratories	473
Gyne-Cytology Laboratory	494
Geigy Pharmaceuticals	379
Haug Drug Company	472
Hotel Schroeder	477
House of Bidwell	481
Hurley X-Ray Company	473
Keeley Institute	484
Kennedy-Mansfield	484
Knox Gelatine	483
Lakeside Laboratories	477, 487, 493
Lederle Laboratories	368, 426, 427
Lilly, Eli and Company	386
Linde Air Products	383
Mallard, Incorporated	480
Mallatt Pharmacy	484
Mather Pharmacy	484
Mead Johnson and Company	495
Medical Protective Company	368
Milwaukee Sanitarium Foundation, Inc.	496
New York Polyclinic	369
Orthopedic Appliance Company	487
Parke, Davis and Company	366, 367
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	370, 378
Physicians and Hospitals Supply Company	473
Physicians Casualty Association	480
Pogue, Mary E., School, Inc.	369
Professional Business Service	443
Rennebohm's	484
Riker Laboratories, Inc.	478
Rogers Memorial Sanitarium	496
Sacred Heart Sanitarium	470
St. Croixdale Sanitarium	369
Schering Corporation	opposite 382, 385
Schieffelin and Company	494
Searle, G. D. and Company	465
Sharp & Dohme	372, 373, 381, 475, 485
Shorewood Hospital Sanitarium	477
Smith, Kline & French Laboratories	488
Squibb, E. R., & Sons, Div. of Mathieson Chemical Corp.	374
Time Insurance Company	441
Upjohn	471, 489
Wallace Laboratories	466
Wine Advisory Board	384
Winthrop Laboratories, Inc.	380
Wisconsin Neurological Foundation	479
Wyeth	375, 486

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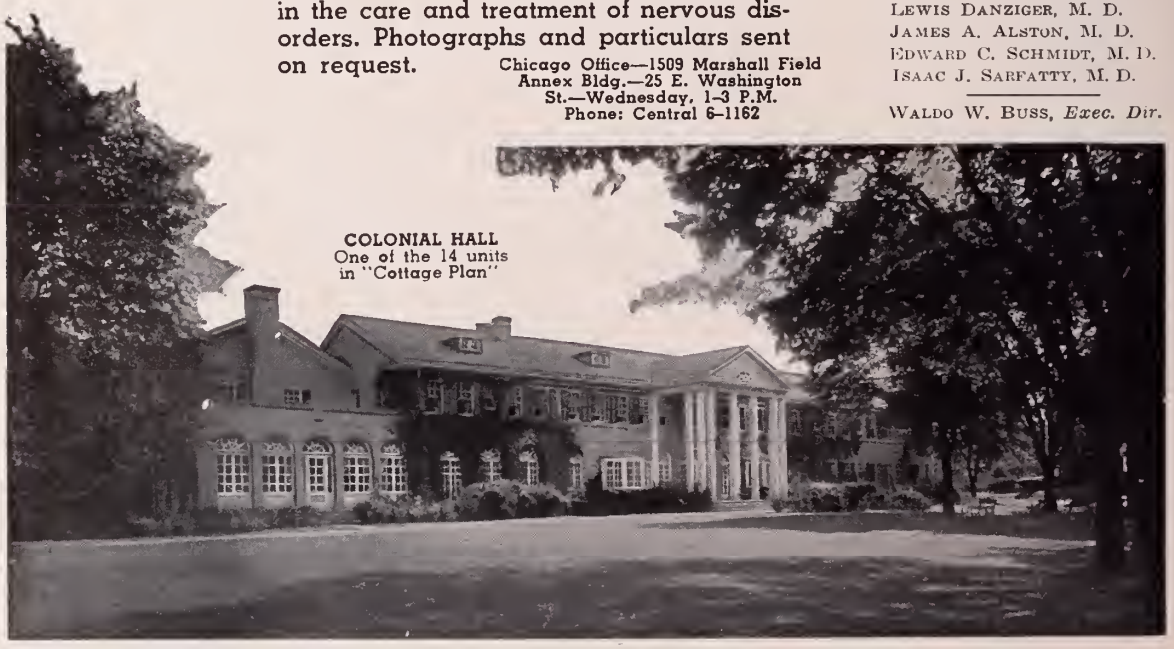

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

Chronic Granulocytic Leukemia With a Prolonged Preleukemic Phase, by Dallas V. Clatanoff, M. D., Ethel W. Thewlis, and Ovid O. Meyer, M. D. ---- 521

Ruptured Intracranial Aneurysm; A Case Report, by David Cleveland, M. D., and Robert E. Swart, M. D. ---- 528

Comments on Treatment ---- 532

Extragenital Phallus; Case Report, by Vernon J. Hittner, M. D., and John Leonard Ford, M. D. ---- 533

The Common Cold and Its Treatment, by Ralph P. Sproule, M. D., F.A.C.S. ---- 536

Current Policy for Gamma Globulin Distribution 542

Clinicopathologic Conference ---- 543

MISCELLANY

Page

L. O. Simenstad, M. D., President, 1956–1957 -- 553

Society Proceedings ---- 554

News Items and Personals ---- 560

Third and Twelfth Districts News ---- 563

Society Records ---- 565

Obituaries ---- 577

Facts About Wisconsin Physicians Service ---- 580

The Journal Bookshelf ---- 581

Physicians' Exchange ---- 586

Index to Advertisers ---- 588

List of Officers and Scheduled Meetings of County Medical Societies ---- 590

EDITORIALS

"To Everything There is a Season . . ." ---- 552

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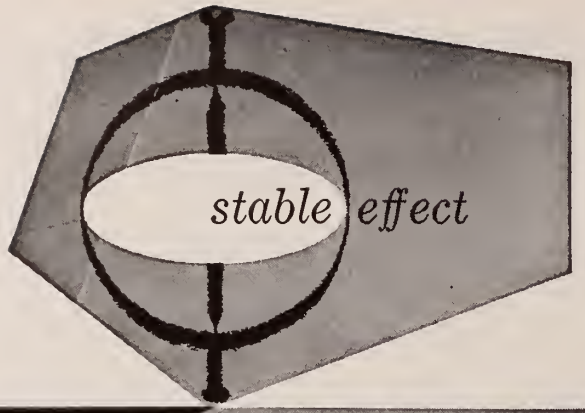

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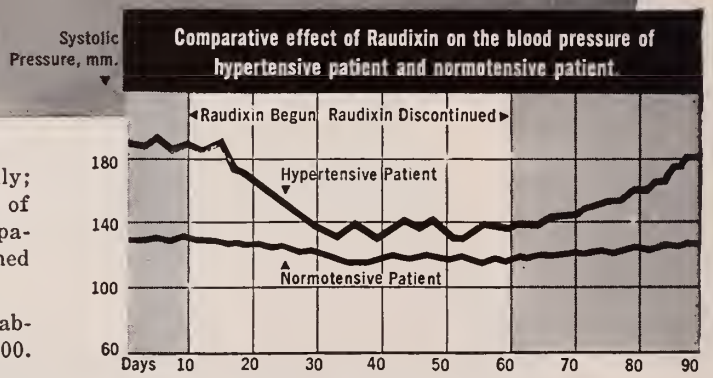

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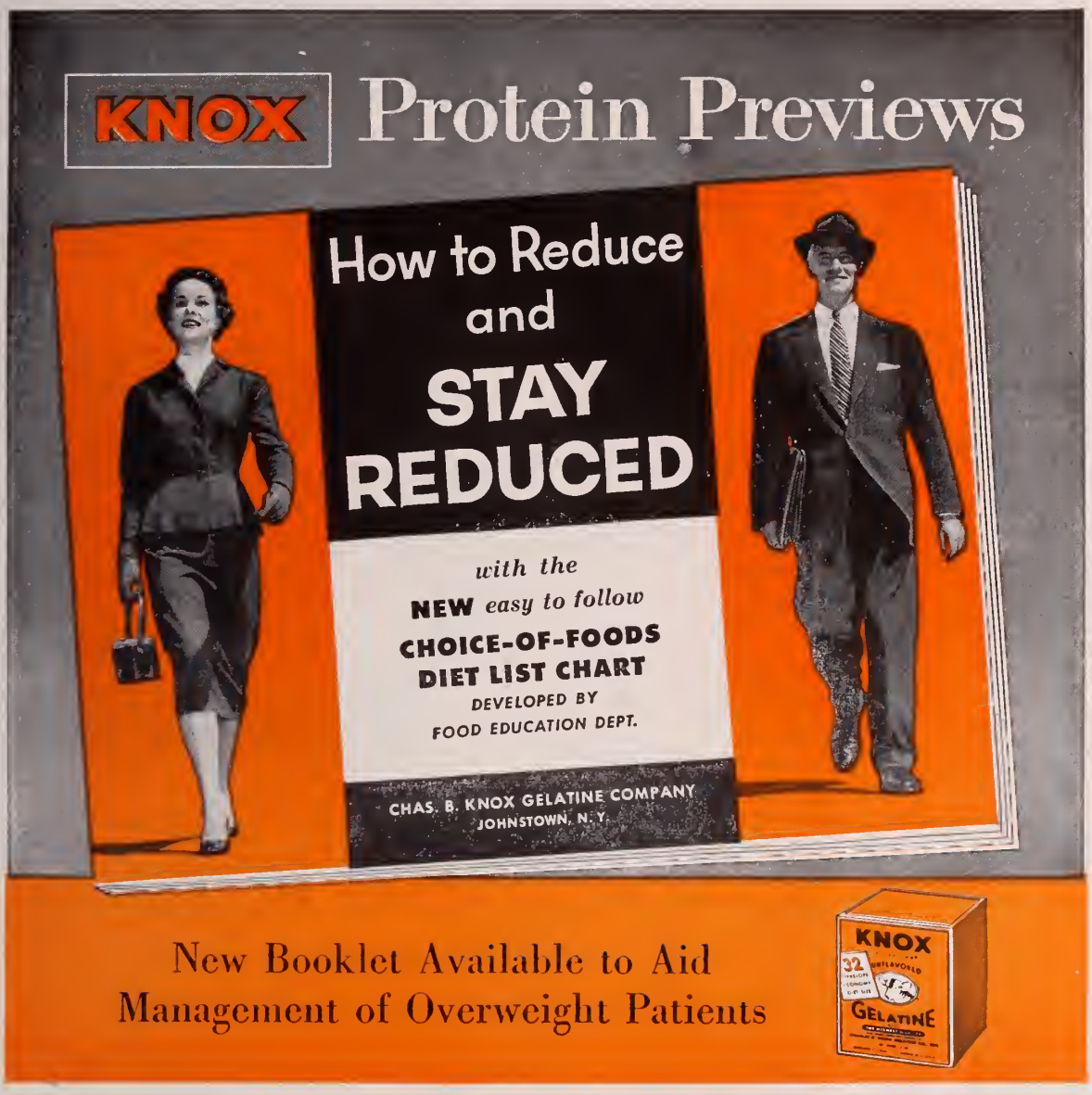

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1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

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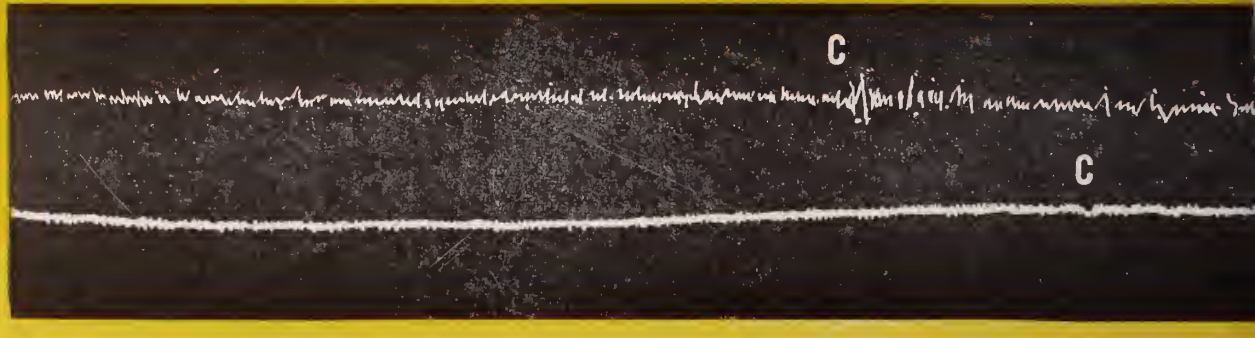

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1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

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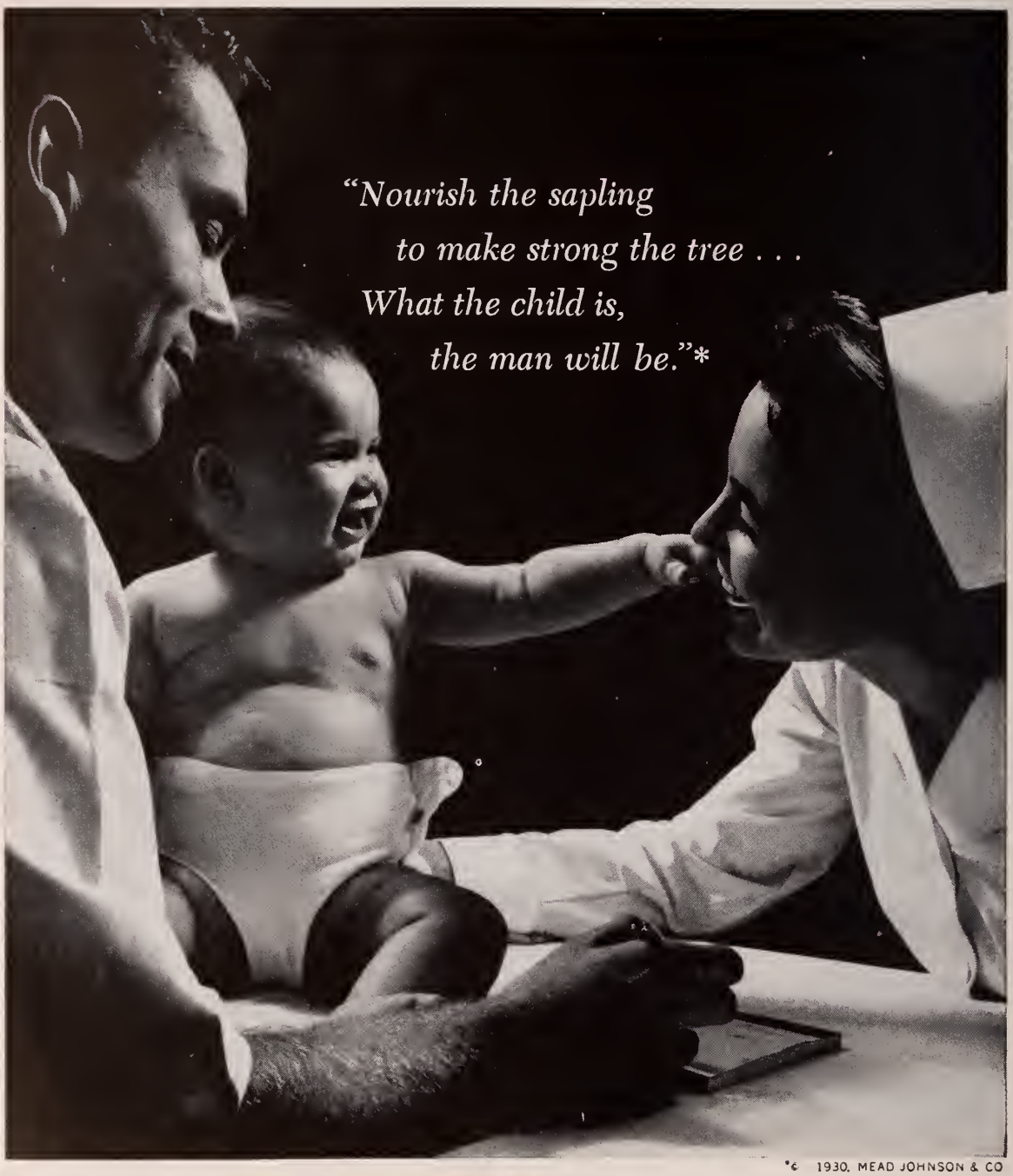

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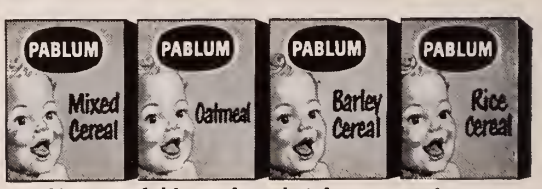

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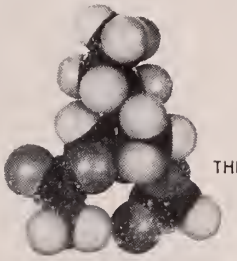

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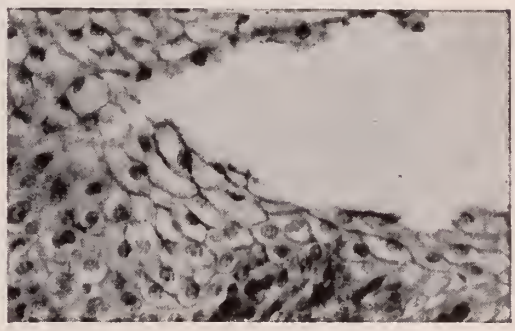

TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

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Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

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References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

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1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G.C.E.; Drummond, J.C., and Sandstead, H.R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.

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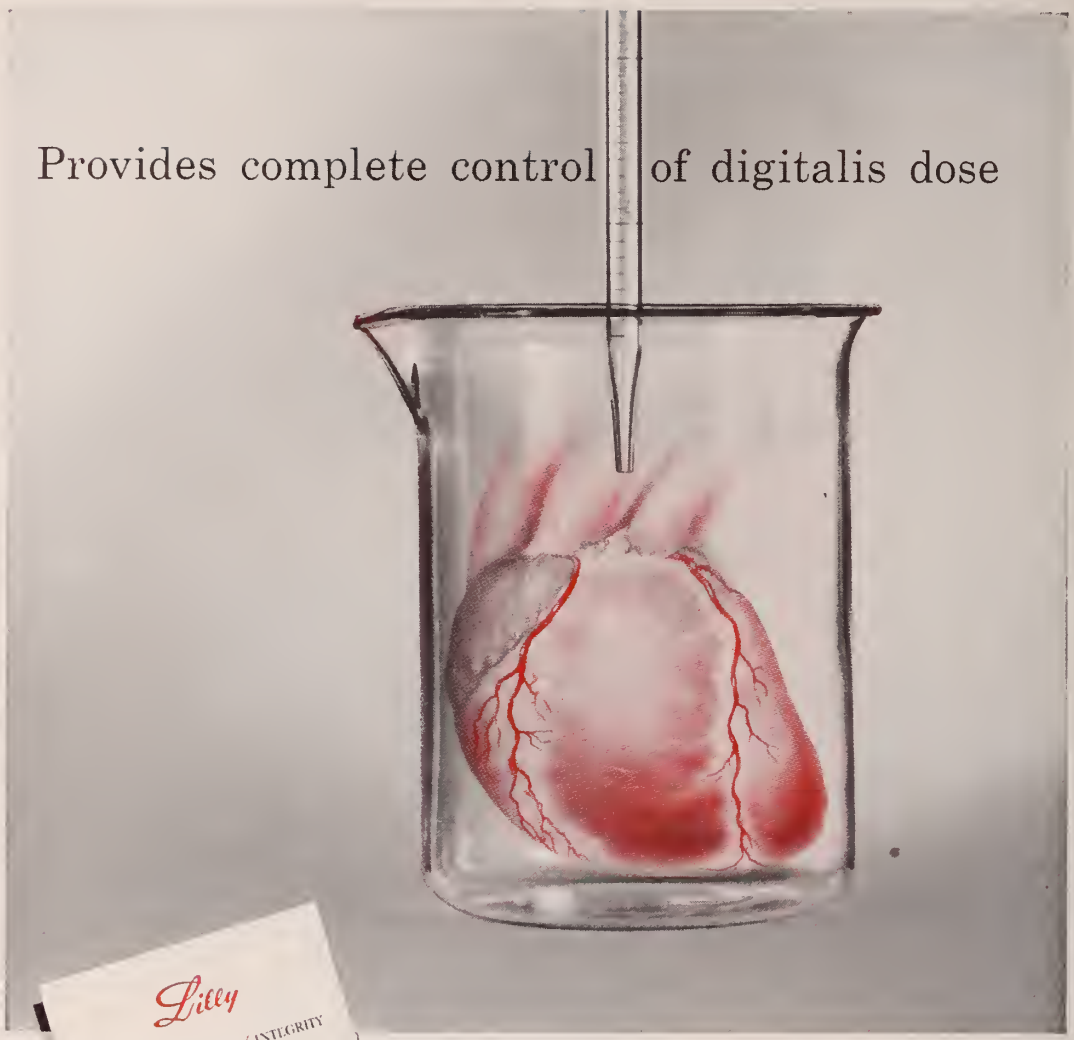

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Volume 55 MAY 1956 Number 5

Chronic Granulocytic Leukemia With a Prolonged Preleukemic Phase*

By DALLAS V. CLATANOFF, M. D., ETHEL W. THEWLIS, and OVID O. MEYER, M. D.
Madison

IN RECENT years the early hematologic manifestations preceding the onset of clinically recognizable leukemia have been well described and documented.[1,2] Anemia, leukopenia, neutropenia, and thrombocytopenia in various combinations may exist. Our report concerns a patient with severe anemia and mild leukopenia who was closely observed for 30 months. The diagnosis of myeloid leukemia, which had a rapidly fatal course, was not established with certainty until three months before death.

Case Report

The patient, a 65-year-old white woman, had been known by one of us (O.O.M.) since 1926. On Sept. 8, 1952, she was admitted to the hospital. Her past history did not appear to be relevant. For some months prior to Sept. 6, 1952, it had been noted by the patient's associates that she seemed tired and pale; and they had insisted upon her seeing a physician in the out-patient department. She complained of being "all in" and extremely tired, of a fever as high as 103 F. at night, a sense of fullness in the abdomen for two or three weeks, anorexia, a weight loss of 15 pounds (10 pounds in the past six weeks), general aching, and some headache. There had been no change in bowel habits and no paresthesias. Because of a rather vague abdominal complaint, this patient had been previously seen in the out-patient department in March, 1951, at which time the urinalysis was normal, a gastrointestinal series negative, a cholecystogram normal, and the blood uric acid 4.3. The blood count showed the hemoglobin to be 12.6 gm.; erythrocytes 4,030,000; and leukocytes 4,310, with segmented cells 42%, band cells 13%, lymphocytes 42%, and monocytes 3%. There was a family history of carcinoma in one brother, who died during the course of the patient's present illness; of heart disease in another brother; and of hypertension in a sister.

Physical examination revealed a short, well-developed, pallid woman who was 5 feet, 1 inch tall, and weighed 168 pounds. Icterus, splenomegaly, and lymphadenopathy were absent. The lungs were clear. The heart was of normal size with a systolic apical murmur heard over the precordium and a systolic aortic murmur transmitted to the neck. The blood pressure was 164/94. The liver was 5 to 6 cm. below the costal margin on deep inspiration. There was rather severe localized tenderness to deep palpation just above the umbilicus, and this persisted throughout the patient's illness. There were varicosities of the legs. The reflexes were normal, and the vibratory sense was intact. Pelvic examination showed no abnormality.

Extensive laboratory studies included several normal urinalyses. The admission blood count revealed a hemoglobin of 7.8 gm.; erythrocytes 2,360,000; reticulocytes 1.8%; and leukocytes 5,030, with 54.9% neutrophils, 1.6% eosinophils, 30.9% small lymphocytes, 2.5% young lymphocytes, 9.2% monocytes, and 0.9% unclassified cells. The platelets were increased in the blood smear. Marrow study after sternal aspiration showed a considerable amount of fat and a moderate number of marrow particles. In a differential count of the marrow, neutrophils were 19.9%; eosinophils 2.6%; metamyelocytes 6.7%; neutrophilic myelocytes 11.0%; eosinophilic myelocytes 5.7%; promyelocytes

*From the Department of Medicine, University of Wisconsin Medical School.

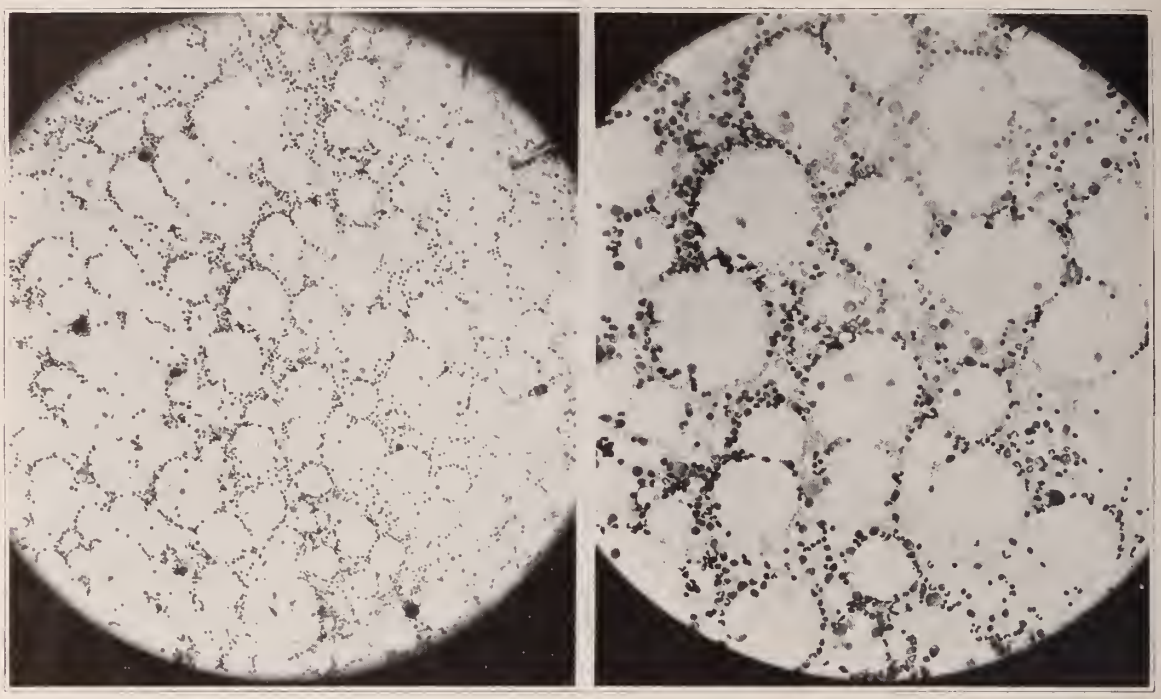

Fig. 1—The bone marrow aspirate from the sternum. September, 1952 (Left, x 75; right, x 150).

2.1%; blasts 3.3%; unclassified 2.4%; small lymphocytes 13.1%; young lymphocytes 12.1%; plasma cells 3.4%; mitotic cells 0.2%; pathological cells 2.2%; megakaryocytes 0.4%; normoblasts 12.6%; pronormoblasts 1.7%; erythroblasts 0.5%; and megaloblasts 0.1%. The majority of the red blood cells in the marrow were well filled with hemoglobin, and there was an occasional polychromatophilic cell. Most of the unclassified cells appeared to be of the lymphocyte series, the myelocytes showed sparse granulation, and the pathological cells appeared to be of the myeloid series. The blood Wassermann was negative.

The blood sugar was 109 mg. and nonprotein nitrogen 26 mg./100 cc. of blood. Gastric analysis revealed the presence of free acid after histamine. The prothrombin time was 77%. A stool examination was 2+ positive for blood, with the use of gum guaiac; but two other stool examinations were negative. Stool cultures were negative for *Salmonella* and *Shigella*. Two blood cultures were negative. The icterus index was 5.3 units. Hanger's cephalin flocculation test and a thymol turbidity test were negative. The proteins totaled 7.4 gm., with the albumin 5.1 gm., the globulin 2.3 gm./100 cc. Serum amylase was 48 units. Repeatedly, blood smears showed the platelets to be increased. Upon repetition of the liver function tests, the prothrombin time was found to be 80%; but the other studies (including icterus index, serum proteins, and Hanger's test) were as before.

A chest x-ray showed no significant change other than sclerosis of the aorta. Intravenous pyelograms were normal. A gastrointestinal series was negative, as was an x-ray of the colon following barium enema.

Surgical marrow biopsy, done on October 25, showed a normal cellular marrow except for a slight increase in megakaryocytes; there was no fibrosis.

The patient was treated with injections of liver and vitamin B_{12} in full dosage for one month without reticulocyte response or improvement.

A positive diagnosis could not be made on the basis of the above studies; but because of the suspicion that the patient had a carcinoma of the pancreas, exploratory laparotomy was done on September 23, with biopsy specimens obtained from the liver and pancreas. The pancreas was normal, and tissue from the liver demonstrated a granulomatous hepatitis. Acid-fast stains were negative.

Postoperatively, the patient received iron, folic acid, and polyvitamins without retic-

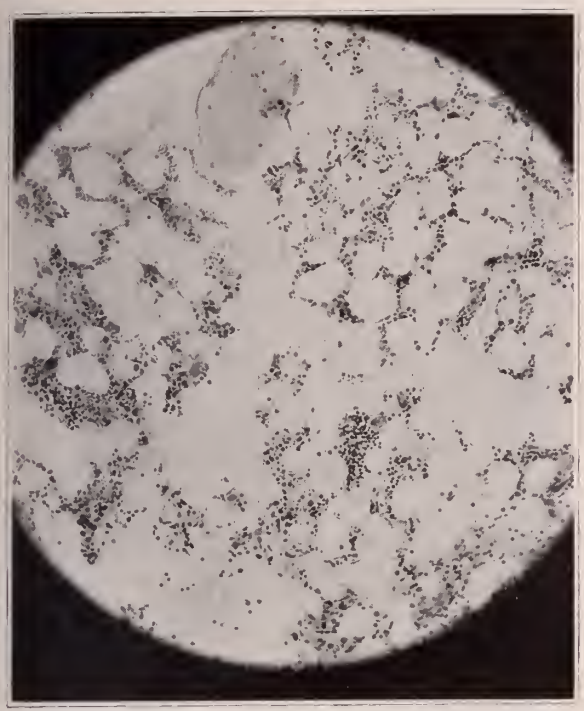

Fig. 2—The bone marrow obtained from the sternum by surgical biopsy, Oct. 25, 1952 (x 75).

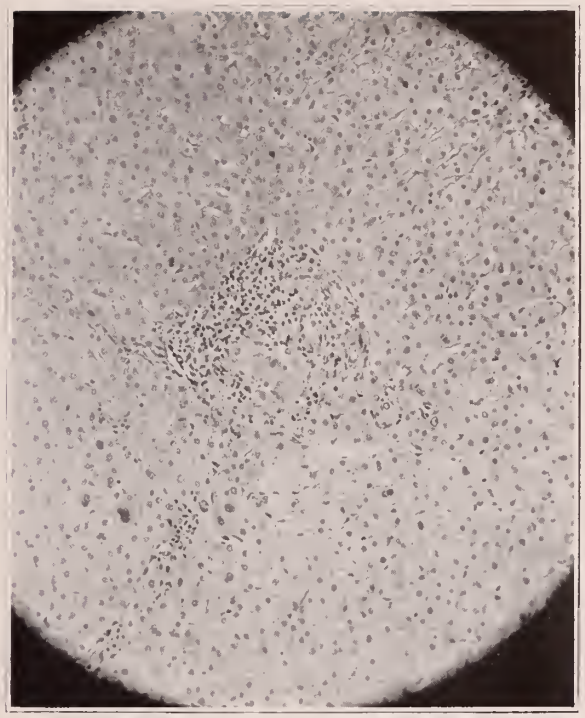

Fig. 3—The granulomatous lesion observed in the liver (x 150).

ulocyte response or improvement in her hematologic condition. An increase in eosinophils developed in the peripheral blood to a maximum level of 13% on October 23. The patient was discharged on November 2 with no diagnosis made.

She was then seen in the out-patient department, and continued to take iron until the time of her next admission to the hospital on December 9, when she received three 500 cc. blood transfusions.

On Jan. 4, 1953, the situation was about the same as it had been on Dec. 9, 1952. The patient had had a good holiday in Colorado, having spent about three weeks there. Although she was not energetic, she felt exceedingly well. The physical findings were as before; and the hemoglobin was 9.5 gm., red blood cells 2,980,000, and white blood cells 3,290. By February 11 she was working five to six hours a day but limiting her outside activities. Three transfusions had been given from January 13 to 15. Physical examination showed nothing significantly new, and the hemoglobin was 9.8 gm. and erythrocytes 3,340,000. Beginning at this time 75 mg. of cobaltous chloride was given in three divided doses daily for three months, without benefit.

The patient then returned to her work and had no particular complaints. She was readmitted on February 25 and discharged on February 27, having received additional blood transfusions.

When she reported again to the out-patient department, she had been working more than half time. Although she had felt relatively well, she had had some evening fever, up to 99.4 to 99.8 F. She appeared to have good nutrition, although she continued to be pallid. There was no lymph node enlargement other than a tiny supraclavicular node. The blood count on March 17 was as follows: hemoglobin 9.4 gm.; erythrocytes 2,820,000; hematocrit 29%; reticulocytes 0.2%; mean corpuscular volume 102.8 cubic microns; mean corpuscular hemoglobin 33.3 micromicrograms; mean corpuscular hemoglobin concentration 32.4%; leukocytes 3,750; neutrophils 65.8%; eosinophils 2.9%; small lymphocytes 20.1%; young lymphocytes 3.6%; monocytes 6.4%; unclassified 0.6%; and eosinophilic myelocytes 0.6%. The platelets were increased in the smear. At this time the patient was having longer intervals, of about four to six weeks, between each series of two or three transfusions.

She was seen irregularly thereafter and received eight transfusions as an out-patient; they were usually given when the hemoglobin levels were between 8 and 9 gm., the erythrocyte count between 2,500,000 and 2,800,000. The last three blood transfusions in this period were given between July 20 and 22. The patient had taken ferrous sulfate in the form of Feosol regularly and a poly-vitamin.

She next entered the hospital on October 28, following a fall due to slipping on the floor. At that time she had sudden pain in the left wrist. A fork deformity of the wrist was found, and x-ray examination confirmed the presence of a line fracture, about 1.5 cm. long, of the radial articular surface. The interpretation was Colles' fracture, and a closed reduction under nitrous oxide and morphine was done. The patient had no particular difficulty in recovering from this procedure. She was hospitalized until November 2, and received two 500 cc. transfusions.

On November 26 an acute respiratory infection developed. The patient was seen in the out-patient department on November 30, at which time it was concluded that she had acute suppurative otitis media, for which a myringotomy was done. She was hospitalized on December 1 and had an uneventful recovery, her temperature returning to normal by the fourth hospital day. She received 300,000 units of penicillin twice a day, analgesics, and five blood transfusions during this hospital residence. Her blood count prior to the transfusion of blood showed a hemoglobin of 5.9 gm.; erythrocytes 2,750,000; and leukocytes 14,100 with neutrophils 78%, lymphocytes 22%.

During January, 1954, the patient had no complaints; and, when seen on Feb. 15, 1954, she appeared to be of fair color and nutritional state. The nasal and oral mucous membranes were pallid; the sternum was tender; and the keloid scar, which had been noted for more than one year, was present at the site of surgical biopsy. There was no lymph node enlargement. The fundi were normal. The lungs were clear, and the heart as before, with the blood pressure 158/76. The liver was 5 cm. below the costal margin, but the spleen was not felt. The reflexes and extremities were normal, and the vibratory sense was intact. It was at this time that a note was made to the effect that the patient might ultimately demonstrate leukemia, and it was advised that sternal aspiration be done before the next transfusions.

She continued to be seen irregularly during 1954. She had been receiving cortisone from mid-October, 1953, 25 mg. three times a day for four weeks; after this interval 25 mg. twice a day was administered until the dose was tapered in December, 1954. From Jan. 4, 1954, until Dec. 22, 1954, she required no transfusions. She was at work regularly until Nov. 6, 1954, when she was hospitalized overnight for an acute gastroenteritis with transient fever to 100.8 F. At this time the spleen was first found to be palpable 4 cm. below the costal margin on deep inspiration.

She was seen in the out-patient department on Dec. 1, 1954, when she stated that she had had continuation of an upset of the gastrointestinal tract which was mild in degree until just a few days before. She complained that she had had a cold again and complained of severe chest pain. This chest pain had been present for several weeks, but the patient had not reported it; and it persisted for more than two weeks after she was seen. At this time she showed a total of eight or nine purpuric areas, 2 to 5 cm. in size, on the arms, thighs, and legs. There were a few medium moist rales at the lung bases posteriorly. The heart was as before, and the blood pressure was 134/80. The liver was 7 cm. and the spleen 5 cm. below the costal margin on deep inspiration.

Bone marrow aspiration was again done December 6, and the examination showed changes characteristic of a chronic granulocytic leukemia, with a distinctly hyperplastic marrow.

The patient was then told her diagnosis, and she was given four x-ray treatments of 100 r. each to the spleen. The cortisone dosage was tapered and finally stopped December 15 but was resumed December 20; later the patient was also given doses of 20 units each day of ACTH intramuscularly.

She was admitted to the hospital again on December 22. In the afternoon she was given 500 cc. of whole blood (the first since January, 1954) and developed a chilly sensation. The next day she had fever to 100 F. However, symptoms of the reaction promptly subsided, and she was discharged from the hospital on December 24. She stated that she still had some cough, which was nonproductive, and still had some pain in the left lower chest. It was noted that her ecchymoses had

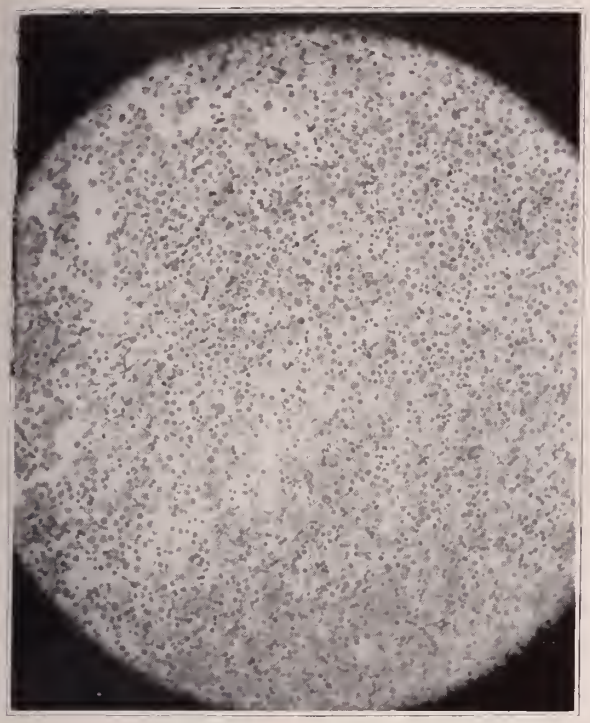

Fig. 4—The bone marrow aspirate from the sternum. Dec. 6, 1954 (x 75).

lessened since she had had x-ray therapy. At this time the spleen was 8 cm. and the liver 8 cm. below the costal margin. She was given 20 units of ACTH twice a day for the next two days, since cortisone had been completely withdrawn. She received a second transfusion.

The blood count on December 21 was as follows: hemoglobin 8.1 gm.; erythrocytes 2,930,000; hematocrit 28.5%; reticulocytes 5.3%; leukocytes 16,650, with 43.8% neutrophils, 0.4% eosinophils, 1.0% basophils, 2.2% metamyelocytes, 17.8% small lymphocytes, 12.4% young lymphocytes, 1.4% atypical lymphocytes, 18.2% monocytes, 0.4% unclassified, 0.6% neutrophilic myelocytes, 1.2% blasts, 0.2% pathological cells, and 0.4% normoblasts. The mean corpuscular volume was 97.2 cubic microns, the mean corpuscular hemoglobin 27.6 micromicrograms, and the mean corpuscular hemoglobin concentration 28.7%. The urinalysis was negative.

The patient then returned to work and seemingly was feeling reasonably well. She was seen in the out-patient department on Jan. 12, 1955. She had had slight nausea while receiving her x-ray therapy. She had noted purpuric areas and petechiae on the face and extremities. The puffiness of the face which had developed as a result of the previous cortisone therapy had largely disappeared.

On physical examination the impression was gained that the patient was generally better. There were still some petechial areas on the face and trunk and a few rales in the left axilla. There was less tenderness of the thorax than there had been a month before. The spleen was 7 cm. below the costal margin on deep inspiration. The blood studies on January 17 were similar to those of the preceding December.

After arising on the morning of February 9, the patient felt nauseated and had some diarrhea. She then felt faint. She twisted her right ankle, with subsequent pain. An x-ray of the ankle showed a linear fracture of the lateral malleolus in the form of a fracture line, and the patient was hospitalized.

Physical examination at this time showed nothing particularly new. The spleen was 5 to 6 cm. below the costal margin, the liver as before; and there was some epigastric tenderness. The blood count was as follows: hemoglobin 8.9 gm.; erythrocytes 2,235,000; hematocrit 27%; reticulocytes 4.9%; leukocytes 37,500, with 60.6% neutrophils, 2.6% metamyelocytes, 10.0% small lymphocytes, 4.0% young lymphocytes, 12.6% monocytes, 0.6% unclassified, 4.2% neutrophilic myelocytes, 3.8% blasts, 1.2% pathological cells, and 0.4% normoblasts. The mean corpuscular volume was 120.5 cubic microns, the mean corpuscular hemoglobin 39.7 micromicrograms, and the mean corpuscular hemoglobin concentration 32.9%.

The patient had fever the night of admission, to 101 F., and continued to have fever until February 15, at which time penicillin was administered. She was afebrile thereafter. Achromycin, which had been given from February 10 to 14, was without apparent effect. The patient's general appearance was satisfactory on February 11, but on the next day it became evident that she was more toxic and extremely weak. There were a moderate number of rales at both lung bases. She suddenly became much worse on February 15 and, when seen at 3:15 p.m., was very dyspneic. Oxygen administration was started. She was given 2 mg. of Myleran three times a day; this was continued through February 18. She was fatigued, clammy, and distinctly pallid. The pulse was feeble, the blood pressure 60/30. She was

given a 500 cc. blood transfusion handled in silicone materials, and cortisone was administered. Thereafter she received a similar transfusion each day. On February 16 the nonprotein nitrogen was 146 mg., creatinine 3.6 mg./100 cc. of blood. A urinalysis showed no abnormality. On February 17 the patient seemed tired and feeble and was icteric. On the next day she complained of severe left upper quadrant pain; by that time she was deeply icteric, but the stools were of normal color. There developed many more petechiae and scattered areas of ecchymoses. There were only a few rales in the lungs. She was unable to eat and was given parenteral fluids. Her condition was very poor on February 19. She slept most of the time and slipped into coma, expiring the afternoon of Feb. 19, 1955.

Pathological Findings

Post-mortem examination was done, and the findings showed the changes of chronic granulocytic leukemia with infiltration of the liver, spleen, lungs, and adrenals. There was moderate transfusional liver hemosiderosis; no granulomatous lesion such as that seen in the biopsy was noted. There were hemorrhages in the spleen, lungs, heart, kidneys, uterus, lymph nodes, bone marrow, and adrenals, with necrosis in the adrenals as well. Figure 5 shows the bone marrow findings.

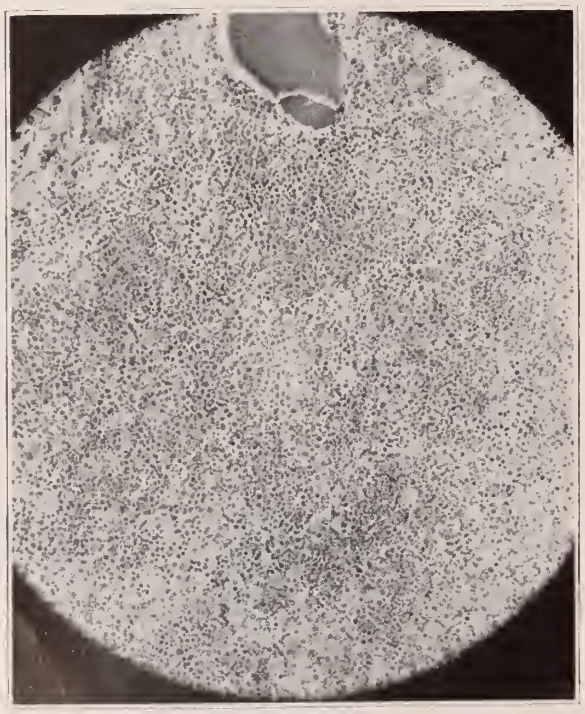

Fig. 5—The bone marrow as seen post mortem (x 75).

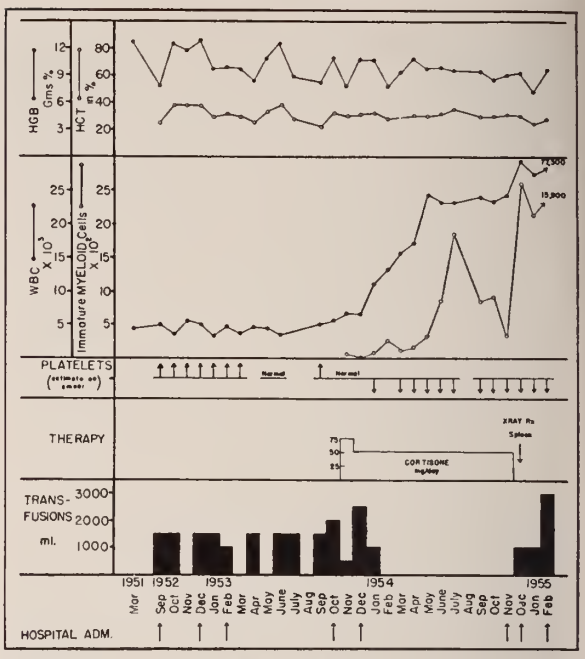

Fig. 6—The hematologic changes occurring over a 30-month period.

Discussion

This case represents another example of long-standing anemia which was finally diagnosed as leukemia, chronic in type, from both the clinical and hematologic standpoints. The patient was observed unusually closely since she worked in the same hospital as did the authors. Block, Jacobson, and Bethard[1] have noted that the preleukemic phase is usually considerably longer than the leukemic, which was true of this patient, too, although the cases they reported were of the acute variety. The hematologic course of our patient over the 30-month period is charted in figure 6.

The response to therapy in our patient was never satisfactory, although the need for transfusions was lessened while she received cortisone. Once the diagnosis of leukemia was made, the response to roentgen therapy was at best only fair. Poor response to therapy when the condition is once diagnosed has also been the experience of Meacham and Weisberger.[2]

It was suspected early in 1954 that leukemia was developing because of the changes in the blood smears; *i.e.*, increase in leukocytes after a long period of leukopenia and, for the first time, a decrease in platelets. The reticulocytes were never greater in number than normal until the terminal phases

of the illness. However, the possible role of increased hemolysis accounting for the anemia was never properly established or ruled out. The improvement with cortisone therapy is suggestive but not conclusive, since it is occasionally beneficial in leukemia. Whether or not excessive hemolysis existed is not crucial, however, since, regardless of the mechanism, a long preleukemic phase did exist. Meacham and Weisberger[2] found that in 7 of their 10 cases a hemolytic process was present.

The diagnosis is extremely difficult in these cases prior to the development of the leukemia. However, we would emphasize the importance of a high index of suspicion. The one suggestion that may have utility is that special attention should be given to large numbers of platelets in the blood smears. The combination of anemia and a gross increase in platelets rarely occurs if there is no blood loss, and it ordinarily suggests but two conditions, namely, chronic granulocytic leukemia and Hodgkin's disease. Leukopenia, conversely, is present in these preleukemic phases as in this patient, and it may exist with Hodgkin's disease.

The granulomatous lesion demonstrated in the biopsy of the liver is not explained. It may have some significance, and hence we call attention to it here, although what its significance is, if any, cannot be stated at this time.

Summary

A closely followed case of chronic granulocytic leukemia, with a preleukemic phase of at least 27 months, occurring in a woman of 65, is reported. The possible diagnostic significance of thrombophilia in association with anemia, especially if there is also leukopenia, is suggested.

(O. O. M.) 1300 University Avenue.

REFERENCES

1. Block, M., Jacobson, L. O., and Bethard, W. F.: Preleukemic acute human leukemia, J.A.M.A. 152: 1018–1028 (July 11) 1953.
2. Meacham, G. C., and Weisberger, A. S.: Early atypical manifestations of leukemia, Ann. Int. Med. 41:780–797 (Oct.) 1954.

ANNUAL CLINICAL DAY

Marquette University Medical School Dean's Committee

Veterans Administration Hospital, Wood, Wisconsin, Saturday, June 9, 1956

8:30 a.m.: Congenital Hemorrhagic Telangiectasia with Ocular Manifestations—Paul R. Thornfeldt, M. D., Ophthalmology

8:45 a.m.: Congenital Hemorrhagic Telangiectasia with Otolaryngologic Manifestations—Shigeo Shinkawa, M. D., Otolaryngology

9:00 a.m.: Serum Transaminase and Fibrinogen Levels in Myocardial Infarctions—Robert F. Madden, M. D., Internal Medicine

9:15 a.m.: Enterocolitis on the Surgical Service—Derward Lepley, Jr., M. D., Surgery

9:30 a.m.: Periodic Fever—Charles W. Magnuson, M. D., Internal Medicine

10:00 a.m.: Effect of Induced Thyroid Abnormalities on the Growth of Transplantable Mammary Cancer in Mice—Wayne J. Boulanger, M. D., Surgery

10:15 a.m.: Intermission

10:30 a.m.: Evaluation of Surgical Treatment of Herniated Lumbar Intervertebral Discs—E. Kenneth Rath, M. D., Orthopedics

10:45 a.m.: Hypochromic Anemia—Indications for Exploratory Laparotomy—John J. Carolan, M. D., Internal Medicine

11:00 a.m.: Mechanism and Prevention of Cutaneous Necrosis Due to Noradrenaline—A. Stephen Close, M. D., Surgery

11:15 a.m.: The Use of Hypothermia in Anesthesia—Martin J. Denio, M. D., Anesthesiology

11:30 a.m.: Sialography and Sialolithiasis—Richard W. Moss, D.D.S., Dental

11:45 a.m.: Rehabilitation of the Hemiplegic Patient—Paul A. Dudenhoefer, M. D., Physical Medicine

12:00 noon: Werner-Rothmund Syndrome—Harold D. Rose, M. D., Internal Medicine

12:15 p.m.: Complications of Acute Pancreatitis—Howard L. Kuhl, M. D., Surgery

7:00 p.m.: Dinner Dance—Circus Room, Wisconsin Hotel

Ruptured Intracranial Aneurysm

A Case Report*

By DAVID CLEVELAND, M. D.
Milwaukee
and
ROBERT E. SWART, M. D.
Hayward, California

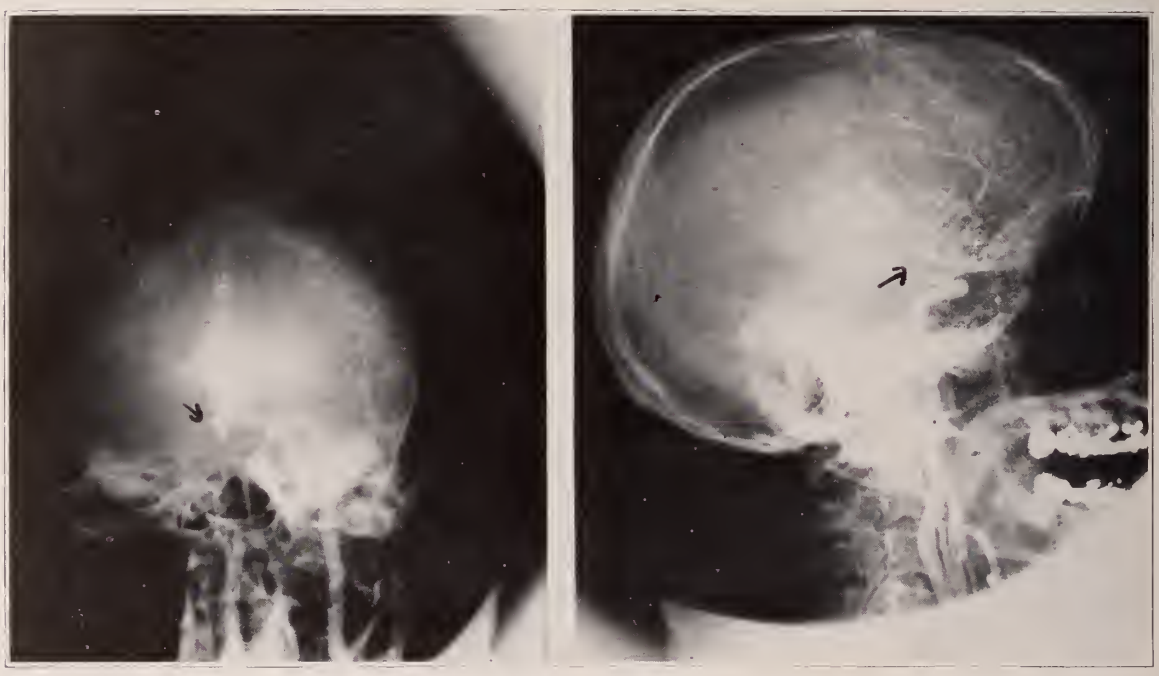

Fig. 1a—Preoperative left carotid angiogram (A–P view) revealing an aneurysm of the left anterior cerebral artery.

1b—Preoperative left carotid angiogram (lateral view), again demonstrating the aneurysm.

IMPROVEMENT in operative technique and in anesthesiology has resulted in lower operative mortality in the treatment of intracranial hemorrhage due to ruptured aneurysm. Methods of diagnosis and treatment have been thoroughly documented.[1-6] In brief, the diagnosis of ruptured aneurysm is considered in patients with acute or subacute episodes of partial or complete collapse, headaches, neck rigidity, photophobia, and hemiparesis or paralysis. Ocular palsies, particularly of the third and fourth nerves, occur frequently in the presence of a ruptured aneurysm. Occasionally the attack is ushered in with or followed by a convulsion. Blood is always present in the spinal fluid in spontaneous subarachnoid hemorrhage due to a ruptured aneurysm, whereas blood is seldom present in the spinal fluid in intracerebral hemorrhages except when it breaks through into the ventricles or subarachnoid spaces.

Cerebral arteriography usually enables accurate diagnosis and localization. There is a growing tendency to use it early in the course of the illness as it has been established that arteriography does not raise the intra-arterial pressure or promote further bleeding. The time for its use must be estab-

*From the Surgical Service of the Veterans Administration Center, Wood, Wisconsin, and Marquette University School of Medicine, Milwaukee. Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Fig. 2—Preoperative right carotid angiogram (lateral view), demonstrating absence of the right anterior cerebral artery.

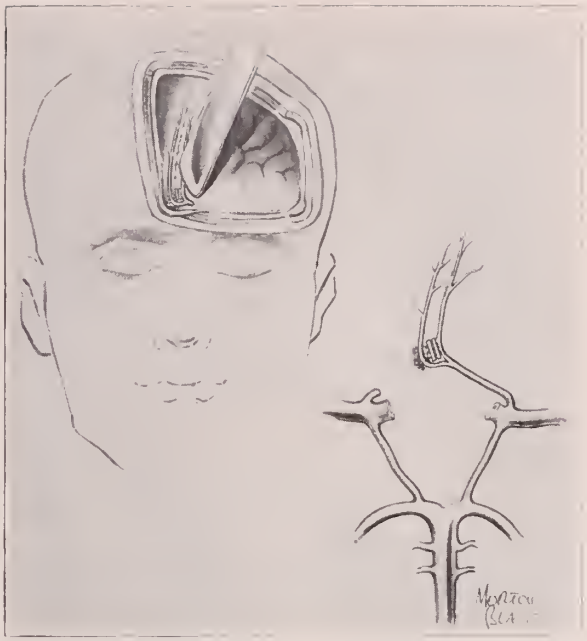

Fig. 3—Artist's drawing of the operative findings, including the aneurysm clipped at its base, and the lack of communication between the right internal carotid artery and the right anterior cerebral artery.

lished by clinical judgment and acumen in each case. It is becoming generally recognized that favorable prognosis depends on surgical treatment rather than medical or nonsurgical therapy.

The most commonly utilized operative measures include (1) ligation of the common or internal carotid artery in the neck, (2) ligation or clipping of the neck of the aneurysm, (3) trapping of the neck of the aneurysm by occluding the parent artery, and (4) reenforcing the wall of the aneurysm by means of a foreign substance such as muscle or cotton.

Recently on our Neurosurgical Service we encountered an unusual case in which both anterior cerebral arteries arose from the left internal carotid artery without communication with the right internal carotid. This prevented ligation of the left internal carotid artery in treatment for a rupture of an aneurysm of the left anterior cerebral artery. It is felt that the case is of sufficient interest to warrant its reporting.

Case Report

The patient, a 34-year-old man, entered the hospital on Feb. 4, 1953, as a transfer from another hospital in the city where he had been under observation. His general health had been good until the evening of Jan. 5, 1953, when he noted the sudden onset of a "blackout spell" followed by a severe occipital headache, nuchal rigidity, impaired hearing, and the sensation of water flowing along the scalp from the left temporal area to the occipital region. A few hours later he had several emeses. These symptoms subsided only to recur a few days later, leading to the initial hospitalization.

Evaluation, including cerebral angiography (figs. 1 and 2), resulted in the diagnosis of intracranial hemorrhage from an aneurysm of the left anterior cerebral artery. An additional finding from the angiograms was that both the left and right anterior cerebral arteries had their origin from the left internal carotid artery, contraindicating ligation of the left common or internal carotid artery in the neck.

A third episode of bleeding occurred on January 23, but at the time of transfer to this hospital the patient was alert and complained only of a low-grade occipital headache and slight nuchal rigidity. The only definitely abnormal physical finding on admission was lateral gaze of the right eye with inability to converge. Babinski sign was equivocally present bilaterally. The pa-

Fig. 4—Postoperative left carotid angiograms in the A–P and lateral views, showing the two metal clips in place.

tient's condition remained essentially unchanged until February 11, at which time progressively severe headaches and anorexia with persistent vomiting developed. Also, he became more and more lethargic during the next several days until he was comatose and regarded as nearly moribund.

On February 18 a left frontal craniotomy was performed under hypotensive anesthesia. Confirming the original angiography diagnosis, both anterior cerebral arteries originated from the left internal carotid artery with no demonstrable communication between the two internal carotid arteries. A narrow-necked, 4.0 mm., berry-type aneurysm was found on the medial aspect of the left anterior cerebral artery approximately 3.0 mm. distal to its origin. The pedicle was occluded at its neck by means of two silver clips without obliterating the lumen of the left anterior cerebral artery (fig. 3). Following this, the blood pressure was raised to 156 mm. Hg. systolic to verify hemostasis, and closure was effected without incident. During the first three days postoperatively the patient was confused, but this situation rapidly improved. During the first week he was febrile and had occasional episodes of transitory hypotension. A repeat cerebral angiogram (fig. 4) on April 15 did not reveal any defect; and, after short periods when he left the hospital on leaves of absence, the patient was discharged on April 18.

Initially, the patient's most distressing postoperative difficulty was partial memory loss, manifested mainly by the inability to remember his wife's correct first name. This situation resolved spontaneously after two weeks. Reexamination at frequent intervals after discharge from the hospital revealed steady improvement in mental status for approximately eighteen months. At times the patient is still somewhat evasive when asked a series of complex questions, but he has returned to all normal activities and recently returned to college for the completion of his studies.

Summary and Conclusions

1. Surgical measures are accepted methods of therapy in cases of ruptured intracranial aneurysm, the specific procedure often varying with the findings in the individual case.

2. An unusual case is presented in which both anterior cerebral arteries arose from the left internal carotid without demon-

strable connection with the right internal carotid. Successful treatment was by intracranial approach and clipping of the neck of the aneurysm of the left anterior cerebral artery. Results have been excellent, and a two-year follow-up is now completed.

(D. C.) 324 East Wisconsin Avenue.

REFERENCES

1. Bassett, R. C., List, C. F., and Lemmen, L. J.: Surgical treatment of intracranial aneurysm, Surg., Gynec., & Obst. 95:701–708 (Dec.) 1952.
2. Dandy, W. E.: Intracranial Arterial Aneurysms, Ithaca, N. Y., Comstock Publishing Company, 1944.
3. Falconer, M. A.: Surgical treatment of bleeding intracranial aneurysms, J. Neurol., Neurosurg., & Psychiat. 14:153–186 (Aug.) 1951.
4. Hamby, W. B.: Treatment of ruptured intracranial aneurysms, Surg. Clin. North America, 1063–1075 (Aug.) 1954.
5. Poppen, J. L.: Symposium: intracranial vascular abnormalities; specific treatment of intracranial aneurysms; experiences with 143 surgically treated patients, J. Neurosurg. 8:75–102 (Jan.) 1951.
6. Steelman, H. F., Hayes, G. J., and Rizzoli, H. V.: Surgical treatment of saccular intracranial aneurysms; report of 56 consecutively treated patients, J. Neurosurg. 10:564–576 (Nov.) 1953.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WHBY	Appleton	Saturday	8:30 a.m.
WATW	Ashland	Saturday	8:15 a.m.
WHSA	Brule	Saturday	1:15 p.m.
WHKW	Chilton	Saturday	1:15 p.m.
WCHF	Chippewa Falls	Saturday	9:00 a.m.
WHWC	Colfax	Saturday	1:15 p.m.
WHAD	Delafield	Saturday	1:15 p.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Saturday	4:00 p.m.
WBAY	Green Bay	Saturday	2:45 p.m.
WHHI	Highland	Saturday	1:15 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:30 a.m.
WHA	Madison	Saturday	1:15 p.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	11:45 a.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Friday	1:45 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Saturday	1:15 p.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:30 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Saturday	1:15 p.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	9:15 a.m.
WBKV	West Bend	Saturday	11:30 a.m.
WHLA	West Salem	Saturday	1:15 p.m.

Comments on Treatment

Editor—HARRY BECKMAN, M. D., Marquette University, Milwaukee

What Price Oral Penicillin?

If the experience of Mohler and associates at Boston University is representative, it appears that the answer to my question may have to be that any price is too great to pay. These observers prescribed a routine schedule of potassium penicillin G 200,000 unit tablets to be taken three times daily by mouth for seven days by 217 patients aged 15 years or less and 28 patients aged over 15 years. The maladies for which the drug was prescribed were acute pharyngitis or otitis media due to beta hemolytic Streptococcus.

Of the 245 patients, **161** (65.7%) stated that they took oral penicillin for seven days as prescribed, and 84 (34.3%) admitted taking less than the prescribed amount. When the need for penicillin was emphasized, those taking the full course increased to 70.9%. It

Performance in Younger and Older Age Groups

Performance	No. Patients		%
Patients aged 0-15			
Penicillin as prescribed	147		67.7
Less penicillin than prescribed	70		32.3
Total	217	(88.1%)	100.0
Patients aged over 15			
Penicillin as prescribed	14		50.0
Less penicillin than prescribed	14		50.0
Total	28	(11.9%)	100.0

appears from the table shown here that parents were more conscientious about administering the drug to their children than they were about taking it themselves, but appearances may be deceiving since the disparity in numbers in the two groups precludes attributing statistical significance to the difference.

This report certainly makes it appear that lack of cooperation on the part of the patient should be considered as a serious deterrent to the routine use of orally administered penicillin for the effective treatment of ambulatory patients with streptococcic infections. It makes one feel very jittery, too, about the effective prophylaxis of rheumatic fever when the responsibility for taking the penicillin tablets is left in the hands of the patient or the parents.

It is interesting to note that the most frequent reason given by patients for not taking the drug as prescribed was that they felt well after one or two days of therapy. Other reasons were the refusal of children to take the drug, misunderstanding on the part of the patient, insufficient money with which to purchase the drug, and just plain carelessness. It is noteworthy that patients receiving free medication did not differ in performance from the others.—HARRY BECKMAN, M. D.

REFERENCE

1. Mohler, Daniel N., Wallin, David G., and Dreyfus, Edward G.: Studies in home treatment of streptococcal disease. I. Failure of patients to take penicillin by mouth as prescribed, New England J. Med. 252:1116–1118 (June 30) 1955.

RE: ARTICLE ON "WEIL'S DISEASE"

The following letter was received after the publication of the article, "Weil's Disease," in our March, 1956, issue:

"Dear Sir:

The Journal, in its recent March number, printed an article on Weil's disease, by Shapiro and Smith.

We wish to call your attention to our publication in your Journal, volume number 42, April, 1943, on the first reported case in Wisconsin.

Respectfully yours,

/s/ JACOB M. FINE, M.B.
/s/ WARREN J. CONEN, M. D."

The original article was: Fine, Jacob M., and Conen, Warren J.: Leptospira Icterohaemorrhagiae (Weil's Disease): A Study of the First Reported Case in Wisconsin, Wisconsin M. J. 42:408–413 (April) 1943.

Extragenital Phallus

Case Report

By VERNON J. HITTNER, M. D.,* and JOHN LEONARD FORD, M. D.**

Seymour Green Bay

MUCH has been written on the subject of pseudohermaphroditism, but a search of the literature has failed to produce a case of extragenital phallus similar to the one we wish to report.

History: The patient was a well-developed and well-nourished white female child, aged 9. The parents, who are both normal in all respects, noticed a small "growth" near the vulva of their child at birth. The "tumor" continued to enlarge slowly until the present time (figs. 1 and 2).

Fig. 1—Preoperative view showing the relation of the penilelike mass to the vulva and anus.

Physical examination of the child was negative except for the finding of a penile-like protrusion approximately three centimeters in length situated at a point five centimeters lateral to the vulva on the left side. There was no abnormality of the labia, clitoris, urethra, vagina, or uterus. The penile-like protrusion had a rather firm consistency and was covered with loose epidermis, especially at its distal end. No urethral meatus or aperture of any kind was visible. A complete blood count and a urinalysis were negative.

Surgical excision of the penile-like protrusion was performed at St. Vincent's Hospital, Green Bay.

Pathological findings: Gross: The specimen had a polypoid appearance and measured 2.6 cm. by .6 cm. to 1.2 cm. The entire specimen, except for the proximal end, was covered with epidermal tissue, which was intact. On cut section, it was seen that practically the entire volume of the subcutaneous tissue was occupied by an encapsulated, pale yellowish, slightly hemorrhagic, firm mass.

Fig. 2—Preoperative view showing relation of penile-like lesion to the vulva.

*F.A.C.S.; F.I.C.S.; Chief of Surgery, St. Vincent's Hospital, Green Bay.

**Fellow, American College of Pathologists; Director, Pathological Laboratory, St. Vincent's Hospital, Green Bay.

Fig. 3—Low-power view showing relation of skin and subcutaneous areolar tissue to the cavernous body.

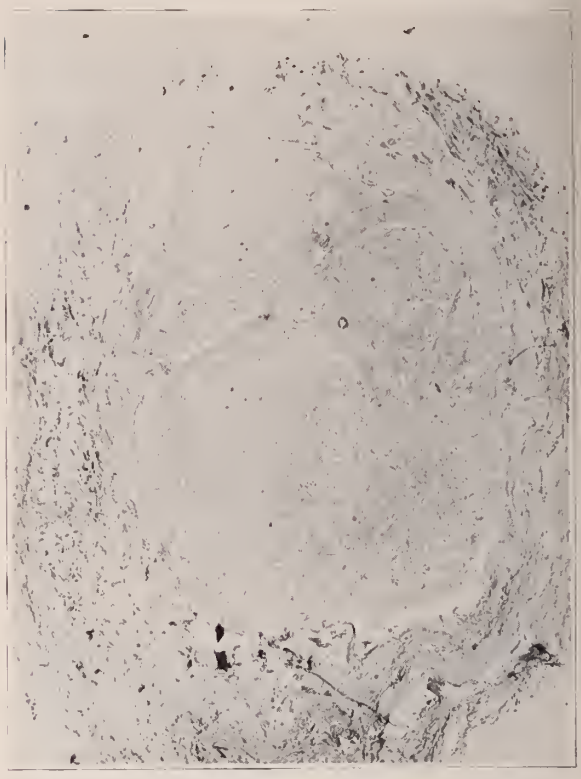

Fig. 4—Low-power cross section view of penilelike lesion showing the urethral opening and the trabecular pattern of the parenchyma.

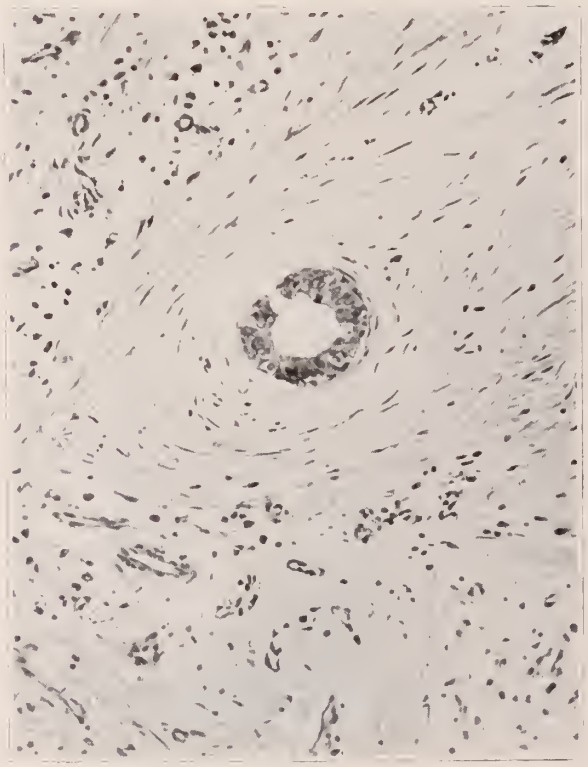

Fig. 5—Medium-power view showing the relation of the vascular cavernous body to the urethral opening.

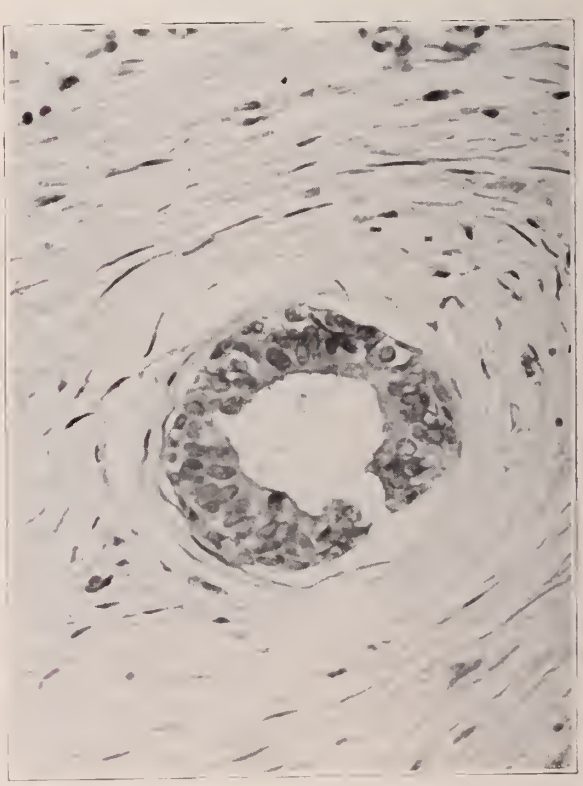

Fig. 6—High-power view of the urethral opening showing the transitional type of epithelial lining.

Microscopic: (figs. 3, 4, 5, and 6.) Sections through the proximal third of the penilelike specimen showed normal epidermal tissue and normal subcutaneous tissue surrounding a parenchyma which had the appearance of the corpus cavernosa of a penis. Only one cavernous body was present; and this was surrounded by a rather dense, fibrous, elastic membrane which was made up of a peripheral longitudinal and an inner circular layer. On the medial aspect of this inner circular layer there was a layer of connective tissue which contained many small veins. The greater portion of the cavernous body was made up of erectile tissue composed of numerous trabeculae. Interspersed in the trabeculae were irregularly shaped spaces composed of loosely arranged, smooth muscle cells which coursed in all directions without any specific arrangement. Occasional connective tissue fibers and occasional plasma cells and histiocytes were interspersed in this loose, smooth muscle tissue. Near the periphery of the cavernous body was a reduplicated urethra which was lined with transitional cells of three-cell depth. In the loose, smooth muscle tissue were enormous numbers of small veins, some of which contained red blood cells. These small capillaries and veins apparently lacked a muscular wall. In the midportion of the penile-like specimen the urethral opening was not present, but the histologic appearance was otherwise exactly as that noted above. In the distal third of the penile-like specimen a single urethral opening was noted in the central portion of the cavernous body and this was also lined with transitional cells. The histologic appearance of this distal third was similar in all respects to that of the proximal third.

The pathologist's diagnosis, "anomalous penis of congenital origin," confirmed the clinical impression that this was an extragenital phallus of congenital origin.

Pseudohermaphroditism or congenital intersexuality is a developmental anomaly of unknown etiology, in which characteristics of basically one sex are exhibited. The true sexual nature at times may be difficult to determine since the external genital pattern may closely resemble that of the opposite sex. In this particular case the basic sex is undoubtedly feminine.

Since there was no valid reason for intra-abdominal exploration, we are uncertain at this time whether or not this penile process represents the external manifestation of pseudohermaphroditism.

(J.L.F.) St. Vincent's Hospital.

REFERENCES

1. Matheson, Iain: Genital abnormalities in two sisters, J. Obst. & Gynaec. Brit. Emp. 57:450–453 (June) 1950.
2. Panos, Theodore C.: Female pseudohermaphroditism with hypodrenia, Pediatrics 5:972–986 (June) 1950.
3. Young, Hugh Hampton: Genital Abnormalities, Hermaphroditism and Related Adrenal Diseases, Baltimore, The Williams and Wilkins Company, 1937.
4. Smith, Franklin R.: True hermaphroditism, Northwest Med. 52:1022–1025 (Dec.) 1953.
5. Hinman, Frank, Jr.: Advisability of surgical reversal of sex in female pseudohermaphroditism, J.A.M.A. 146:423–429 (June 2) 1951.
6. Perloff, W. H., and Brody, M. W.: Clinical management of male pseudohermaphrodite, Postgrad. Med. 10:337–340 (Oct.) 1951.

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The Common Cold and Its Treatment*

By RALPH P. SPROULE, M. D., F. A. C. S.
Milwaukee

Definition

THE common cold is defined by Gohd[1] as follows: "An acute epidemic respiratory disease characterized by mild coryzal symptoms of rhinorrhea, nasal obstruction and sneezing. The nasal discharge is usually copious and thin during the first two days of illness after which it becomes viscous and purulent."

As to the course of a cold, it can be one day or two weeks. It can be accompanied by fever, sore throat, and a cough. In itself a common cold is harmless. The difficulties arise when the bacterial invaders follow with a secondary infection, producing sinusitis, mastoiditis, meningitis, brain abscess, or pneumonia.

It is unfortunate that the above clinical description is not pathognomonic for the common cold but may apply to other pathological entities, including respiratory allergy.

Clinical Features

The common cold, however, does have definite clinical features. With the onset there is a constitutional reaction of malaise, chilliness, dullness, aching, and often some slight fever—perhaps 99.4 F. There is local burning with dryness of the mucous membrane of the upper air passages. These symptoms may start in the nose or as low as the larynx. They may go up or down depending on the starting point. One examines the patient in these early stages and even though he is very uncomfortable, few, if any, abnormalities can be seen. Although the disease is self-limited, a dry cough, a raw nose, and fatigue can persist for weeks. At this point it is most important to note there is never any heavy purulent exudate unless or until secondary infcction sets in.

Incidence

The common cold is for all purposes present everywhere in the world. It has been found in the tropics, the temperate zones, and the Arctic Circle. In the United States colds occur more frequently in the fall and the early spring. Small isolated communities in the Arctic Circle have enjoyed a freedom from them for many months during the winter providing no contacts were made with outside shipping. In Spitzbergen colds are prevalent during the summer months when the shipping lanes are open. Paul and Freese,[2] in their epidemiological studies on the Spitzbergen Islands, illustrated clearly both the epidemic nature and contagiousness of the cold. The first ship that docked in Longyear City usually brought an epidemic of colds. In less than four weeks 75% of the community had contracted colds.

Urban family studies as carried out by Dingle[3] are most interesting. He presented the following observations:

1. The average rate of respiratory disease was 4.7 attacks for each person per year.
2. Children had almost twice as many colds as adults, 5.86 as against 3.44.
3. Mothers had approximately twice as many colds as fathers, 4.12 to 2.76.
4. If only children of preschool age were in the family, they had an attack rate of 4.86.
5. If there were also school-age children in the family, the preschool child contracted 2 extra colds each year, or a rate of 6.72.
6. The school-age child had a rate of 6.09.

These observations certainly suggest that the school child introduces colds in the family. From the economic point of view, it is virtually impossible to estimate the cost of the disease. Infections of the respiratory tract are encountered more than any other disease. The chief offender is the common cold. Industry loses because of lost working hours. The individual loses because of lost wages and the cash outlays for vitamins, vaccines, baths, drops, gargles, etc.

Treatments That Have Proved Ineffective

These have already been proved worthless for the prevention of colds. Unfortunately, good men get enthusiastic about prophylactic methods or treatments in medicine which later, to their embarrassment, fall of their own weight by the wayside. The fundamental elements of logic were not fulfilled. Their premises did not justify their conclusions.

*Presented at the One Hundred Fourteenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, May 5, 1955, before the Section on Ophthalmology and Otolaryngology.

I will cite examples of enthusiasm. You may remember the sulphur inhalers at the close of the first World War. They were installed in many nose and throat offices and in one leading hospital in this state.

A second example was the tremendous use of vaccines 15 years ago. The lay literature was so full of their virtues that people would come in and demand them. I wrote excuses for my two sons in a private school so they would not be required to take the magic three shots. In addition to many previous statistics on the failure of vaccines, another critical study of 2,000 children of school age was made in Finland in 1953. The conclusion of a paper presented before the Finnish Otolaryngological Society by Professor Sirala[4] on October 18, 1953, was as follows: "The results obtained in the study suggest that the cold vaccine used did not possess definite specific effect on the cold symptoms studied nor on complications following colds when administered in doses prescribed. The clinical significance of bacterial vaccines seems to be extremely doubtful."

Causes of Colds

What do we know about colds and what is the practical way of handling them? As early as 1914 a man named Kruse[5] in Germany, and Foster[6] in 1916 in this country, described the production of colds in volunteers by instillation of filtered nasal secretions from persons in early stages of the disease. However, he was mistaken in attributing a causal role to a small globoid organism. The possibility of a viral cause was ignored for 15 years until Dochez and his associates[7] in 1929 demonstrated the transmission of colds to chimpanzees and to man by a filter passing agent.

Practically all scientists agree now that the common cold is due to a virus or a series of viruses. Dochez has grown the virus in a chicken embryo. It has been demonstrated by Dr. Christopher Andrewes[8] to be smaller than the influenza virus but larger than that of polio. The cold virus is about 2 one-millionths of an inch in diameter. It has never been seen, even under the powerful electron microscope. One might think with this much knowledge we could progress faster in our discovery of the virus in common cold. Perhaps the recent phenomenal culmination of research in polio may be the turning point in our quest. We already know there are more forms of viruses than there are bacteria. However, our knowledge of viruses is about on a par with our knowledge of bacteria at the turn of the century.

Some of the characteristics of the cold virus as described by investigators are as follows:

It is quickly inactivated at — 56 C. Frozen virus has survived for months.

Atlas and Hotler[8] in 1948 were unable to transmit the virus to small animals. There are no serological tests. Andrewes[8] in 1949 stated the cold virus survived at — 76 C. for at least 2 years, and at — 10 C. for at least 27 days. He was unable to infect eggs or small animals. It is important to note at this point that no diseases caused by small viruses have ever been influenced by chemotherapy.

There is a close analogy to influenza, suggesting that the virus spreads intracellularly, injuring the superficial layers of respiratory epithelium. A painful lesion is produced, with no visible change shown. Bloomfield[9] suggests that delay in restoration of the epithelium probably explains the discomfort of the nose and throat after a cold.

It seems reasonably certain that upper respiratory infection is spread by direct droplet transference from one person to another or by infected dust. The prevention of droplet infection limits itself to insuring the best possible ventilation and also affording proper air space for working, living, and sleeping accommodations. Infected dust particles are increasingly thought to be an important factor in the spread of air-borne disease. Dust control is, therefore, an important preventive measure. Dry sweeping should be strictly forbidden. Regular cleaning should be done with suction cleaners and dampened dusters. Although air transmission accounts for the greater part of the spread of upper respiratory infection, other possibilities cannot be neglected entirely. Handkerchiefs, towels, eating utensils, and laundries must be borne in mind as factors.

Both chilling of the body and damp clothes are widely held to be important precipitating factors in the development of respiratory infection. They can only act by lowering the resistance of the body to a concurrently present organism, and their mode of action in this way is by no means certain. They probably act by causing nasopharyngeal congestion and thus facilitate the passing of pathogens through the mucosa. This is borne out

by the observation that differential, not uniform, chilling seems to be the significant factor. Almost any degree of exposure seems to be tolerated outdoors provided that a change of clothes and a warming up are undertaken before sitting down in a stuffy room.

Andrewes[8] in England, in a Harvard Medical School grant study, performed the following experiment:

1. One group of volunteers was chilled only.
2. A second group received virus alone.
3. A third group was chilled and received virus.

The chilling alone caused no colds. Colds were as frequent in those who received virus alone as in those who were chilled and received virus. Andrewes felt this indicated that, under controlled conditions, physical factors which reduced a patient's resistance failed to increase his susceptibility to experimental colds.

The mechanisms that determine the resistance and the susceptibility of man to infection with the cold virus are unknown. An immunity, if present at all, lasts only two weeks. There is still the possibility that the infection in many cases is autogenous.

Prophylactic sterilization of the upper respiratory tract by gargles, sprays, inhalations, and lozenges is a method that has many adherents. Any benefit which might ensue is outweighed by the concurrent damage done the delicate mucous membranes by the solutions and vapors used.

Andrewes and his co-workers believe that the resistance of the population may vary from year to year. In his experimental group in 1947, 55 to 60% of volunteers became infected with colds. In following years there was a decline of takes. In 1953 the low value of 30% was reported.

Use of Antihistamines and Antibiotics

There are no chemotherapeutic or antimicrobial agents that will prevent or alter the course of infections caused by the virus of the common cold. In 1952, Finland,[4] concluded that bacterial vaccines, sulfonamides, antibiotics, and, more recently, antihistamines have been of no value in preventing or altering the course of the common cold.

Lowell and Schiller,[4] in a study made at Boston University on 1,214 subjects with proper controls, conducted experiments with three antihistaminic preparations. In conclusion they stated: "We were unable to distinguish any effect of the three drugs on the common cold that differed significantly from the placebo."

Robert Gohd[1] of the Department of Otology, Massachusetts Eye and Ear Infirmary, in an article on "Common Cold" in April, 1954, states: "The enthusiastic reports of several investigators of the value of antihistamines has not been substantiated because of their lack of proper controls." Subsequently, numerous large-scale, carefully controlled experiments were recorded. Controls were always benefited to the same extent as those who took therapeutic doses of antihistamines.

There were those who stated that, to get the best results, treatments must be started early in the disease. Feller and Andrewes[10] even went one step further. They gave antihistamines two hours before the intranasal inoculation of a group of volunteers. In a second experiment three doses of antihistamines were given 24 to 48 hours before inoculation and continued five days. The antihistamines failed to prevent experimentally induced colds. As a matter of fact, no effect of any kind was observed. The efficacy of antihistamines as either prophylactic or therapeutic agents has not been demonstrated in either naturally occurring or experimentally induced colds. Further comments on the subject are as follows:

1. The Committee on Public Health Relations of the New York Academy of Medicine[11] reported that antihistamines have no value in treatment of the common cold.

2. The Council on Pharmacy and Chemistry of the A.M.A.[12] decried the exploitation by the drug industry of victims of the common cold.

3. The Federal Trade Commission[13] entered complaints against five of the largest manufacturers of drugs, charging misrepresentation and causing a change of advertising policy from claims of cures to claims of symptomatic relief.

4. William J. Kerr[14] wrote: "Never in our time have we witnessed such propaganda for home treatment of any disease based upon such flimsy scientific evidence."

This, then, is the story of antihistaminic drugs in the treatment of the common cold.

It is presently common practice among doctors to give some sort of an antibiotic

such as penicillin, Aureomycin, etc., to their patients with colds. It is important to examine the rationale of such a procedure. These drugs are not effective in small particle virus infections such as influenza. The cold viruses are in this group. It is possible harm may be done by changing the bacterial flora in the respiratory tract. For example, colon bacilli have been known to appear in the throat in almost pure culture after the use of penicillin. These drugs should be reserved for the appearance of the secondary bacterial invaders as manifested by cultures and increased severity of symptoms, particularly a rise in temperature above 99.6 F. This rarely occurs with the common cold.

Treatment

We conclude with the thought that one's only approach to the common cold is to try to prevent it by proper living and proper hygiene. We should make our patients as comfortable as possible by symptomatic treatment. Help them try to avoid complications if possible. If the secondary invaders follow with their possible complications in spite of our efforts, then that opens up an entirely different chapter beyond the confines of this presentation. We know that swallowing extra vitamin pills will not build up resistance to colds. Neither will a special diet featuring citrus juices. Cold showers will not toughen us against the virus. We know that ultraviolet lights will not ward off infections and, also, that alkalizers such as baking soda are valueless. Aspirin and quinine will not help a cold in the slightest degree. They will, however, dull pains and aches. Among U. S. Army patients,[15] bed stay was an average of 48 hours longer in those using laxatives than in those in the control group. One or two alcoholic drinks are comforting, but liquor is harmful if taken in excess. Rest in bed, especially if fever is present, diminishes the severity of the common cold, limits its spread to others, and reduces the frequency of complications. It has stood the test of time as the most sane and effective measure.

Earlier in this presentation it was stated that the new technique for cultivating polio virus in test tubes might aid in the solution of the cold virus problem. Doctor Andrewes[8] of Salisbury, England, and Doctor Huebner[16] of the U. S. Health Service have grown common cold virus in tissue cultures of the human lung, yet they still get plenty of negatives. Until they can produce the cold virus on a large scale in test tubes, they will be a long way from the major question: Can an anticold vaccine be developed?

Doctor Huebner thinks the common cold is the result of six viruses. He has proved that human beings develop antibodies to the six viruses he has isolated. He believes that, using the Enders polio technique for cultivating the six viruses, he can develop a multiple vaccine. However, he said until the cold virus reveals itself through the electron microscope, he will be cautious about any predictions. It is too early to do more than call attention to Huebner's latest work, but it certainly offers promise to the ultimate solution of the problem of the most common complaint of man—the common cold.

208 East Wisconsin Avenue.

REFERENCES

1. Gohd, R. S.: Common cold, New England J. Med. 250:687–691 (April 22) 1954.
2. Paul, J. H., and Freese, H. L.: Epidemiological and bacteriological study of "common cold" in isolated Arctic community (Spitsbergen), Am. J. Hyg. 17:517–535 (May) 1933.
3. Dingle, J. H.: Study of respiratory infections in families, Tr. Am. Acad. Physicians 62:99–104, 1949.
4. Finland, M.: Medical progress: antimicrobial treatment for viral and related infections; antibiotic treatment of acute respiratory infections and influenza, New England J. Med. 247:557–567 (Oct. 9) 1952.
5. Kruse, W.: Die Erreger von Husten und Schnupfen, München. med. Wchnschr. 61:1547 (July 14) 1914.
6. Foster, G. B., Jr.: Etiology of common colds; probable role of filtrable virus as causative factor, J.A.M.A. 66:1180–1183 (April 15) 1916; J. Infect. Dis. 21:451–474 (Nov.) 1917.
7. Dochez, A. R., Shibley, G. S., and Mills, K. C.: Study of acute infection of respiratory tract in ape, Proc. Soc. Exper. Biol. & Med. 26:562–565 (April) 1929.
8. Andrewes, C. H.: Natural history of common cold, Lancet 1:71–75 (Jan. 8) 1949.
9. Bloomfield, A. L.: Some problems of common cold, J.A.M.A. 144:287–292 (Sept. 23) 1950.
10. Andrewes, C. H.: Adventures among viruses. III. Puzzle of common cold, New England J. Med. 242:235–240 (Feb. 16) 1950.
11. Subcommittee of Committee on Public Health Relations of New York: New York Academy of Medicine, Volume 26, 1950.
12. A.M.A. Council on Pharmacy and Chemistry: Status report on antihistaminic agents in prophylaxis and treatment of "common cold," J.A.M.A. 142: 566–569 (Feb. 25) 1950.
13. Lack of effect of antihistaminic drugs on common cold (editorial), New England J. Med. 242:765 (May 11) 1950.
14. Kerr, W. J.: Common cold and its implications, Ann. Int. Med. 33:333–345 (Aug.) 1950.
15. Brewster, J. M.: Common cold can be controlled, Mil. Surgeon 105:441–447 (Dec.) 1949.
16. National sniffles, Newsweek 45:84–88 (Feb. 14) 1955.

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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Current Policy for Gamma Globulin Distribution

As It Looks to Your State Board of Health

THE American Red Cross and the National Foundation for Infantile Paralysis furnish gamma globulin to the State Board of Health for distribution to Wisconsin physicians. The distribution policy pertaining to procedures and material use is determined in part by these agencies, the availability of supply, and the effectiveness of gamma globulin as protection against specific diseases. The American Red Cross has established a 1956 quota that is somewhat less than in past years. Material from this source will be used for diseases other than polio. Material from the National Foundation for Infantile Paralysis is limited to use in poliomyelitis prevention, and the amount that a state receives is established by prevailing disease conditions. Wisconsin has received no assurance of a supply for 1956 from this latter agency, but it anticipates an amount sharply reduced from last year. In order to conserve gamma globulin and assure its availability for diseases wherein it has proven value, it will be provided to physicians for the following disease conditions and contacts.

1. **Measles:** For contacts to clinically diagnosed cases who are not over 3 years of age; for other child contacts declared by their physicians to be in poor general health; and for pregnant contacts. The recommended dose is .01 cc. per pound of body weight with a maximum of 2 cc. for any one person, excepting pregnant women, who may receive 10 cc.

2. **Infectious hepatitis:** For contacts to clinically diagnosed cases regardless of age. The recommended dose, including that for pregnant women, is the same as for measles.

3. **Poliomyelitis:** For contacts to clinically diagnosed cases who have not received vaccine and are not over 30 years of age, and for pregnant contacts regardless of age. The recommended dose is .15 cc. per pound of body weight with a maximum of 20 cc. for any one person. In schools all children confined throughout the day to one classroom, having a case therein, will be eligible for gamma globulin. When children have classes in several rooms, only those seated immediately adjacent to diagnosed cases will be eligible.

4. **Agammaglobulinemia:** When laboratory findings confirm this diagnosis.

5. **Unusual disease circumstances:** In some medical situations where the use of gamma globulin appears indicated, applications for it will be honored. A maximum amount will be established for each circumstance.

Special request forms are not needed to obtain gamma globulin; but physicians must state the nature and age of contacts, the existence of pregnancy, and in agammaglobulinemia and unusual disease circumstances provide additional justifying facts. Limitations placed on the Board of Health make necessary these data. Requests should be directed to the appropriate district health office of the State Board of Health, or in Milwaukee to the Milwaukee City Health Department. Gamma globulin for other than immediate use should not be requested; otherwise, it may become dispersed for possible need rather than remain available for actual need.—A. L. VAN DUSER, M.D.

JOHN HARRIS MEMORIAL LECTURE FUND

A memorial fund has been established in memory of John Harris, M. D., late professor and head of the department of obstetrics and gynecology at the University of Wisconsin. The fund will be used to provide for an annual lecture at the University in the field of obstetrics and gynecology by some nationally known specialist in the field.

Contributions to the fund should be directed to John Z. Bowers, M. D., Dean, University of Wisconsin Medical School.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: James L. Jaeck, M. D.

REPORT OF A CASE*

History

A 53-year-old man was first admitted to the hospital on June 22, 1946, for suspected acute coronary occlusion. During the preceding several months he had experienced spells of acute chest pain, dyspnea, syncope, nausea, and vomiting. Two days before admission, he had had a similar episode of chest pain and syncope. This attack required morphine for relief of pain and was followed by nausea, vomiting, and profound weakness instead of the usual recovery.

Physical findings on hospital admission were not diagnostic. Temperature, pulse, and respirations were normal. The blood pressure was 116/80. The white blood cell count was 11,700 with a normal differential. The hemoglobin was 13.8 gm. (90%), the red blood cell count 4,500,000, and the blood smear not remarkable. The electrocardiogram was considered normal. Chest x-rays showed heavy calcium deposits in the right hilum and a left base pneumonitis. The patient was discharged from the hospital on the eleventh day. At that time the white blood cell count was normal, x-rays showed that the pneumonitis had disappeared, a repeat electrocardiogram was normal, and the patient was asymptomatic.

The next admission to this hospital was on Aug. 22, 1949, about three years later. There is no record of the interval between the 1946 and 1949 hospital admissions. The chief complaint now was productive cough. The patient stated that about three months before, he had been awakened by pain in the left chest, gross hemoptysis, and a shaking chill. Hemoptysis had continued through the night, and he had been taken to a hospital in Madison, where he remained for nine days. The diagnosis was virus pneumonia, and treatment consisted of the administration of penicillin for six days.

Just two weeks after discharge from the Madison hospital he had another episode of left chest pain, without hemoptysis but with productive coughing of rather copious amounts of grayish-white, tenacious sputum. He stayed in bed at home for 10 days with a daily fever up to 102 F. and coughed up two to three cupfuls of frothy white sputum daily. His local physician treated him for recurrent virus pneumonia with Chloromycetin. For the next two months he felt pretty well, and had no chest pain, hemoptysis, or syncope; but he continued to raise large amounts of whitish, but thinner, "frothy" sputum, especially in the morning. The two weeks immediately preceding the second admission to this hospital (Aug. 22, 1949) he had general malaise, some fever, anorexia, dyspnea, and productive cough, but no recurrence of chest pain or hemoptysis. There had been no night sweats.

Past History

The patient had considered his general health good until 1946. He had been confined to bed at home for yellow jaundice when still in high school. In 1923 his local doctor had made a diagnosis of tuberculosis on the basis of weight loss, fever, and hemoptysis; but the patient does not remember that his sputum had ever been positive for tubercle bacilli. His Mantoux test in 1939, however, had been positive. His wife and four children are living and well. The family history is not remarkable.

Physical Examination

Physical findings at this 1949 hospital admission revealed a well-developed, well-nourished, but chronically ill man whose major symptom was a productive cough. There was cyanosis of the lips and some dyspnea, but no orthopnea. The liver was barely palpable and slightly tender. There was no pulmonary osteoarthropathy. The chest was barrel shaped, and increased in anterior-posterior diameter. Expansion of the lungs was equal and symmetrical. Tactile fremitus was in-

* From La Crosse Lutheran Hospital and Gundersen Clinic.

creased on the right, both anteriorly and posteriorly. Vocal fremitus was increased in the same areas. The upper chest on both sides was hyperresonant. There was an area of relative dullness in the left axilla, and bronchial breathing with moist crackling rales in both axillae. There was dullness at the left base posteriorly and hyperresonance at the right base. Moist rales were also heard at both bases posteriorly. The heart sounds were somewhat distant. There was no apparent cardiac enlargement. There was a soft systolic murmur at the pulmonic area, and a snapping pulmonic second sound. Cardiac rate and rhythm were normal. The spleen and kidneys were not palpable, and there were no other abdominal masses or areas of tenderness. Peripheral adenopathy was absent. A neuromuscular examination was negative. The blood pressure was 122/76. There was no peripheral edema and no manifest ascites. The ocular fundi appeared normal. In fact, there were no other remarkable physical findings.

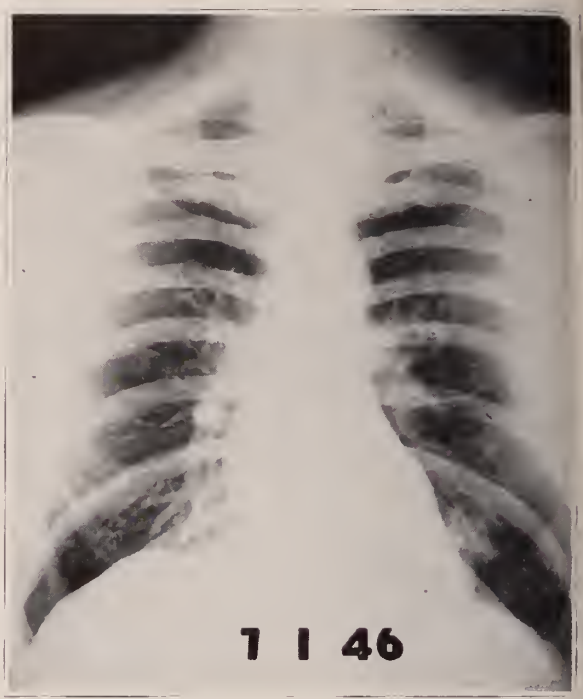

Fig. 1—Chest x-ray (1946). Heavy calcium deposits, right hilum, and pneumonitis, left base.

Laboratory Data

The chest x-rays from 1946 and 1949 hospital admissions are shown here for comparison, and the recorded interpretations of the radiologist are given (figs. 1 and 2).

Only one sputum specimen was submitted for cytologic examination (August, 1949). Papanicolaou stain smears showed numerous well-differentiated, squamous epithelial cells and a few lymphocytes. No malignant tumor cells were seen.

Numerous direct and concentrate smears of sputum stained for acid-fast organisms were all reported negative.

Sputum cultures for tubercle bacilli and fungi were negative on three occasions. Alpha hemolytic streptococci grew on all three cultures.

The histoplasmin skin test was 3+ on two occasions. Second strength tuberculin was equivocal on the same two occasions.

Cold agglutinins were negative in all dilutions on one occasion, positive in 1:16 dilution on another occasion.

Hemoglobin and white and red blood cell counts were all normal (1949). The sedimentation rate was 19 mm. in one hour (Westergren). A urinalysis was essentially negative on many occasions.

A bronchoscopic examination was nondiagnostic. No bronchial biopsy was obtained. Large amounts of tenacious white sputum filled the major bronchi of both lungs.

Hospital Course

During hospitalization from Aug. 22, 1949, to Sept. 23, 1949, the period to which the above data pertains, the patient received intensive antibiotic therapy with little or no effect on his symptoms or on the pulmonary lesions. He did, however, remain afebrile most of this time. He was referred, at the end of this hospitalization, to the county sanatorium for further investigation of the possibility of pulmonary tuberculosis. There was no improvement in the patient's condition at the sanatorium, nor were further bacteriologic studies diagnostic. On Oct. 26, 1949, a needle biopsy of the lung was performed. About six hours after the biopsy, the patient complained of choking sensations in the throat and on the following day developed severe respiratory distress.

He was transferred by ambulance from the sanatorium back to the hospital, where he was found to have a left-sided pneumothorax and extensive subcutaneous emphysema of the left side of the head, neck, and

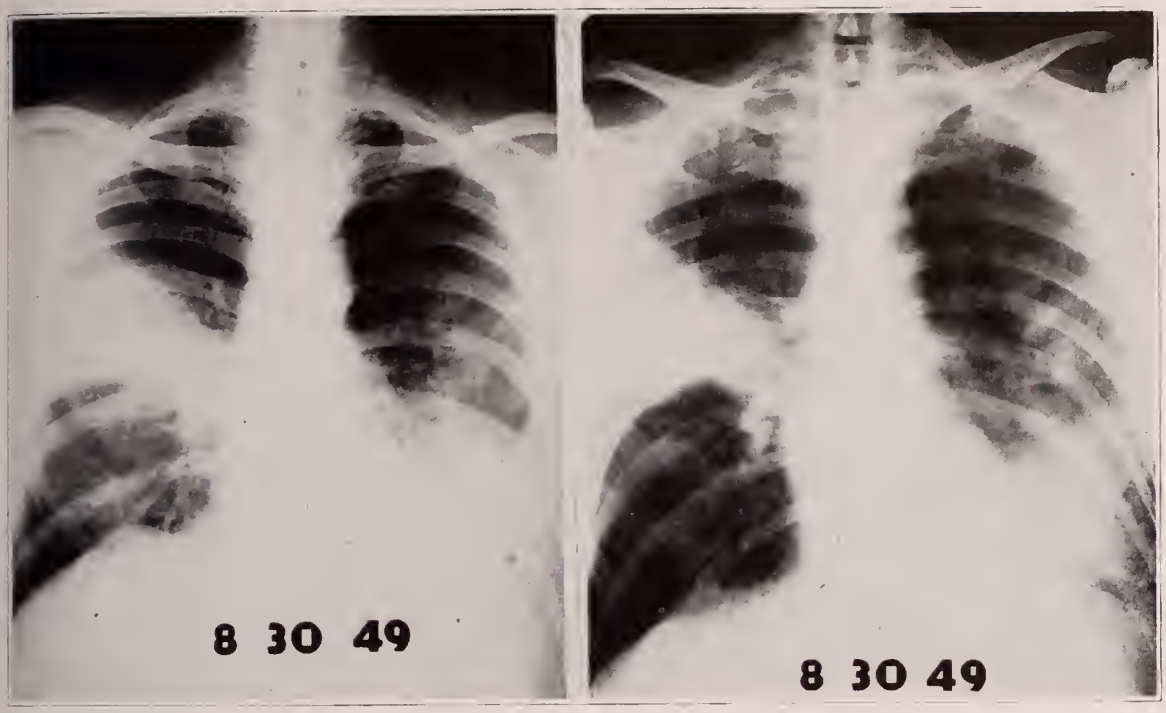

Fig. 2—Chest x-rays (1949)

Interpretation of the chest films of 1949 was as follows: "Extremely fine infiltrative changes resembling 'salt and pepper' effect involve the right upper lobe and left lower lobe. Similar changes involve the right middle lobe, but to a much lesser degree. The lung changes are not likely due to tuberculosis, but most resemble a mycotic infection. Heart and aorta normal."

Chest, P–A and right lateral: "The lung pathology on the right appears confined to the upper lobe. On the left, it may involve the anterior part of the lower lobe. There is a tendency toward nodularity of the pulmonary lesions. There is no evidence of cavitation, but the possibility of small abscesses on the right is entertained."

Bronchograms: "The bronchi to the lower anterior part of the right upper lobe do not fill well. All other right lobe bronchi do fill, but show mild ectasia. The filling defect was thought to be due to interstitial changes in surrounding lung parenchyma. There may be some bronchiectasis in the lower and middle lobes."

trunk. A chest x-ray disclosed a complete pneumothorax on the left. On Nov. 1, 1949, under local anesthesia, a large mushroom catheter was inserted into the left pleural space through the seventh interspace. This afforded temporary relief of respiratory embarrassment and decompressed the emphysema. However, the next day the subcutaneous emphysema was worse than ever. Though the lung re-expanded some, the patient's condition rapidly deteriorated; and he expired on Nov. 2, 1949, about eight days after the lung biopsy. A complete autopsy was performed.

Clinical Discussion

Dr. J. L. Jaeck: We went back into the files a few years to come up with a chest diagnostic problem challenging enough for our thoracic surgeon.

Dr. Harry Burich: Thank you for the special search conducted in my behalf. If you ascribe some mystic diagnostic powers to a chest surgeon, they have failed to light the neon sign spelling out a diagnosis, but rather have left me with a chaotic display of flashing lights, all claiming priority attention.

For the critical analysis of this case, I choose to assume that the immediate cause of death and the basic pulmonary disease were not related except that, because of lung pathology, a biopsy was done. I also feel that the most informative data in this case will be the lung biopsy, which was deleted in the protocol.

If you will now refer to the protocol, I would like to consider certain features of this case in sequence as they are put down in the history, which, as you see, begins in the summer of 1946. I'm sure there would be

honest differences of opinion in this audience as to whether the 1946 illness was, in fact, related to the 1949 illness. It may be a significant point in trying to establish the onset of this man's basic disease process. From the data given us, one cannot be entirely sure whether the 11-day period of hospitalization in 1946 was for lung disease or heart disease. Though acute myocardial infarction or coronary occlusion would not be surprising in a 53-year-old man of sedentary occupation, it would seem that two electrocardiograms 10 days apart should have shown some evidence of myocardial damage. An Adams–Stokes syndrome with arteriosclerotic heart disease might, of course, produce the patient's symptoms, without demonstrable electrocardiogram changes. The mild leukocytosis is compatible with either pneumonitis or myocardial infarction. It is noteworthy that the patient was afebrile during this first illness, and that physical findings were negative. The blood pressure of 116/80 surely discourages any ideas of hypertensive heart disease. In the chest x-rays (figs. 1 and 2), there is little similarity between the 1946 and 1949 lesions, except for the right hilar calcium deposits. I would agree there is a nonspecific pneumonitis at the left base in the 1946 film; but if this is the "discharge" chest film, I disagree with the radiologist that the pneumonitis had resolved at the time the patient left the hospital. There are no bacteriological studies to give any clue to the etiology of this pneumonitis in 1946.

Dr. E. L. Perry: Doctor Jaeck, is there any record of the sedimentation rate, antistreptolysin 0 titer, or C-reactive protein in the 1946 record?

Doctor Jaeck: The sedimentation rate is not recorded. Antistreptolysin titers and C-reactive protein were not done in this laboratory in 1946.

Doctor Burich: We now come to a long time lapse in this man's history (1946 to 1949). All we are told of this three-year period is that about three months prior to the second hospital admission on Aug. 22, 1949, the patient had sudden onset of left chest pain, gross hemoptysis, chills, and cough, and was hospitalized in Madison for nine days with a virus pneumonia treated with penicillin.

We are not told how the diagnosis of virus pneumonia was made. Without seeing the x-rays from Madison, we do not know the site or extent of the pneumonic process. If we knew it again involved the left lung base, it might be significant in deciding on the duration of this man's pulmonary disease and, in fact, the final diagnosis. Gross hemoptysis, to my knowledge, is unusual in virus pneumonia. Without more data, there is no point in speculating on the basis of the history and symptoms as given.

Apparently the patient had a relapse after leaving the Madison hospital. Though hemoptysis did not recur, chest pain and cough continued; and for the first time we are told his cough was productive of large amounts of thick grayish-white sputum. Although the gross characteristics of sputum are not a reliable and diagnostic observation in chest diagnosis, we have been trained to note the character of a patient's cough and sputum. Thick, green, foul-smelling sputum we associate with lung abscess, bronchiectasis, etc. Rusty sputum we associate with heart failure, pulmonary infarction, or pneumonia. Copious, white, frothy sputum is said to characterize bronchiolar carcinoma of the lung. The quantity of sputum has little correlation with the pulmonary pathology because the patient may swallow considerable sputum, may be too sick to raise sputum, or cannot be observed for a sufficient period. Malignancy in the lung may indeed run its entire course with only a dry, hacking, nonproductive cough. Why this man had more sputum in the morning I do not know, unless because of the postural night accumulations of secretions.

Again, we see he received antibiotic therapy, this time Chloromycetin from his local physician, for recurrent virus pneumonia. Without knowing more about the circumstances, I don't believe one can be too critical of the antibiotic treatment, assuming attempts were made to find an etiology for the chest pathology. Admittedly, one reduces the chances of the laboratory isolating an organism if the patient has received therapeutic doses of antibiotics. Also, by antibiotic suppression of the real causative agent, one might be misled by an overgrowth of some secondary organism. It is already well known that 10 years of overutilization of wide-spectrum antibiotics has modified the normal flora of the respiratory tract, gastrointestinal tract, and genital tract. This has created many new and strange problems for the bacteriology laboratory. Nonetheless, every chest diagnostic problem deserves a

complete and early bacteriological work-up, preferably before treatment is started. Even after treatment has begun, sputa and/or bronchial secretions should be submitted for bacteriologic and cytologic examination as long as the diagnosis has not been established.

The past history here is significant only to the extent that one considers the diagnosis of tuberculosis in 1923 reliable. True, the patient had a positive Mantoux test recorded in 1939, and there were calcium deposits in the right lung hilum. The clinical course from 1923 to the present doesn't, in my opinion, fit that of chronic active tuberculous pulmonary disease or these x-rays.

None of the physical findings of the August–September, 1949, hospital admission suggest anything specific to me. The fact that the patient was well developed and well nourished may be evidence against malignancy and any other chronic wasting process. The absence of pulmonary osteoarthropathy discourages, but doesn't exclude, the diagnosis of a malignant pulmonary lesion. The chest physical findings tell me only that there was pathology in both lungs, and that there was probably no consolidation of an entire lobe. I cannot place any diagnostic significance on the murmur over the pulmonic area of the heart; perhaps I should. The heart size was normal on both physical and x-ray examination, and a third electrocardiogram was considered normal. The lack of abnormal physical findings elsewhere pretty well limits the major pathology to the chest and eliminates consideration of a systemic disease.

The chest x-rays constitute the most valuable data we have in this case, and yet they do not characterize any one pathologic process, in my opinion. I agree with the radiologist that there is an infiltrative process involving the right upper and middle lobes and the left base. Aside from the history, this is the first actual evidence of extensive lung disease. There is a suggestion of "honeycombing" in the right lung, visible only when you are close to the film. I think the things mentioned in the original x-ray interpretation are the things to be considered. Tuberculosis involving both lungs to this extent, but not involving the apices, I think would be unusual. The appearance of the pneumonitis otherwise could be tuberculous. I think a mycotic infection of the lungs is the most likely possibility from the x-ray appearances. I prefer to discuss this later on. On the bronchograms I fail to see evidence of bronchiectasis, as reported by the radiologist.

Dr. V. Bruder: My impression at the time was that these bronchi did not fill well due to interstitial fibrosis and not bronchiectasis. The bronchogram was difficult to obtain because the patient was so "wheezy."

Doctor Burich: The only comment I prefer to make on the bronchogram is that there appears to be no primary or intrinsic bronchial lesion or defect. Against the diagnosis of bronchiogenic carcinoma is the presence of multiple parenchymal lesions in the same lung and in the opposite lung without a demonstrable bronchial lesion. In this age group, of course, carcinoma must always be a consideration.

The available laboratory data are not too helpful. The single sputum cytology report of no malignant tumor cells is of no help. One wonders why, if cough was productive of large amounts of sputum, more specimens were not submitted, especially when "numerous" sputa were examined for acid-fast organisms. The negative smears and cultures for tubercle bacilli do not rule out tuberculosis; but with such an extensive process by x-ray, one ought to get at least one positive culture or find acid-fast organisms on concentrate smears if there were pulmonary tuberculosis. A 3+ histoplasmin intradermal test can't be disregarded, especially in the light of hilar calcification. The x-rays would be compatible with pulmonary histoplasmosis. There is nothing to tell us whether or not there is involvement of the reticuloendothelial system. The low sedimentation rate is against a bacterial pneumonitis. The normal blood counts discourage thoughts of a malignancy. The cold agglutination test is inconclusive either way. The bronchoscopic examination, though negative, lacks description, failed to obtain secretions or washings, and was not repeated. All may have been difficult to carry out, I realize. It appears no help was obtained from sputum cultures, but we do not know how extensive these were. The growth of alpha hemolytic streptococci in sputum cultures is not disturbing, and they are not the responsible organisms for the pulmonary pathology in my opinion.

Several of the more likely fungus infections of the lung might be briefly considered.

Actinomycosis is capable of producing the symptoms and x-ray changes we see in this case. Thoracic actinomycosis may or may not be part of generalized or systemic disease. Suppuration and fibrosis characterize infections by this fungus and, when the lungs are involved, formation of chronic sinus tracts to the skin.

Blastomycosis with lung involvement is commonly a chronic suppurative process with nodular consolidation, abscesses, and even cavitation. Bone, liver, spleen, and kidneys are often involved. The lung lesion is more apt to be confined to one lobe or to one lung.

Histoplasmosis has already been mentioned as a distinct possibility here in the light of the hilar calcification and positive skin test, though we have no evidence of generalized reticuloendothelial disease. Coccidiomycosis and cryptococcosis may, of course, involve the lung; but the history and lack of central nervous system involvement make them less likely.

Then there are the so-called nonpathogenic fungi which are often considered saprophytic fungi when found associated with some other lesion in the lung, either neoplastic or inflammatory. The more common of these fungi are *Candida, Aspergillus*, and *Mucor*. In the presence of prolonged or intense antibiotic treatment, these saprophytic fungi are capable of overgrowth in the respiratory tract with clinical pulmonary disease and extensive pathologic lesions. Pulmonary moniliasis, aspergillosis, and mucormycosis are now recognized diagnoses in chest diseases.

The pneumoconioses should be mentioned, and perhaps eosinophilic granuloma, before I venture my diagnosis in this case. We have no history of exposure to dusts or noxious fumes, and usually the pulmonary involvement is more diffuse and involves more lung parenchyma without any confluent lesions. Eosinophilic granuloma can be dismissed without evidence of osteolytic bone lesions and on the basis of the age of our patient.

My diagnoses in order of choice would be:

1. Aspergillosis
2. Blastomycosis
3. Moniliasis

Dr. Thorolf Gundersen: How do you feel about this patient's terminal event in relation to the lung biopsy procedure?

Doctor Burich: The pneumothorax and subcutaneous emphysema induced by the lung biopsy may well have hastened the patient's death. We are not told of any other change in his condition independent of the biopsy. I personally do not feel needle biopsy of the lung is an acceptable procedure since exploratory thoracotomy has become a safe procedure for chest diagnosis. Among other complications of needle biopsy of the lung are hemorrhage and spread of tumor. Open thoracotomy for biopsy has several advantages. One gets a good look at the entire lung and can pick the area for biopsy, and the procedure causes minimal discomfort to the patient. Either general or local anesthesia may be used.

Dr. M. Sivertson: I would like to state that the diagnosis was made on the lung biopsy and is one of the few diagnostic ante-mortem lung biopsies of such a lesion.

Dr. R. Rasmus: Would you exclude the possibility of malignant lung disease, Doctor Burich?

Doctor Burich: No, but because of bilateral disease and lack of a bronchial lesion or atelectasis, I consider carcinoma of the lung unlikely. I have, however, seen a localized unresolved pneumonitis, similar to this 1946 x-ray lesion, blossom forth eight years later as bronchiogenic carcinoma. This probably is because we are unable to see the small neoplasm, but only its effects on surrounding lung parenchyma. Such cases are certainly the exception.

Doctor Jaeck: Though the pathologic and clinical diagnoses disagree in this case, Doctor Burich has enlightened all of us with his approach to this case with the information he was given.

Gross Autopsy Findings

1. Diffuse emphysema–subcutaneous, mediastinum, chest wall, mesentery, perirenal.

2. Tube in left pleural space at sixth interspace.

3. Lungs: Left 1,225 gm.; right 1,150 gm. Voluminous and fills chest *in situ*. Emphysematous blebs, visceral pleura. Loose apical adhesions. Color, slate gray to pink. Consistency, rubbery to leathery. Cut surfaces showed confluent nodular consolidation to large areas of consolidation resembling gray hepatization of lobar pneumonia. Few areas of grayish-white parenchymal infiltrate. Bronchial tree dilated and filled with tenacious white mucus. No intrinsic bronchial lesions. Pulmonary vessels normal. Small

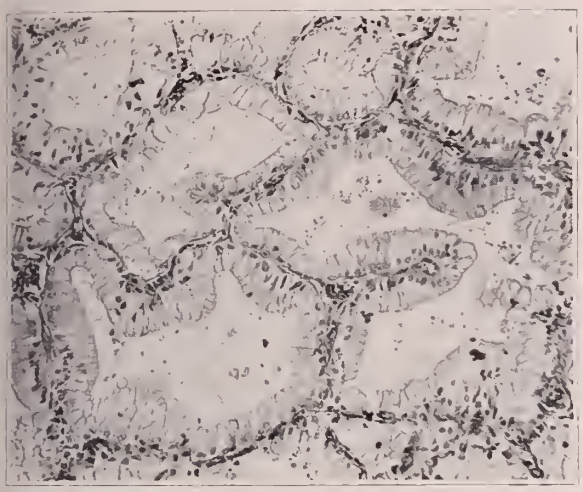

Fig. 3—Alveolar septae lined by tall, pale, mucin-secreting, columnar cells. Alveolar-cell carcinoma. (X 100)

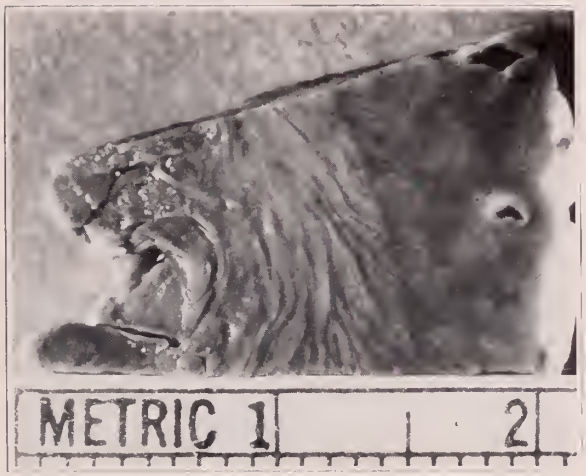

Fig. 4—Hypertrophic right ventricular myocardium. Chronic cor pulmonale due to diffuse pulmonary adenomatosis.

calcified nodes in right hilum. Biopsy site—focal area of necrosis.

4. Heart 250 gm., grossly normal, except hypertrophy of right ventricular myocardium.
5. Liver 1,200 gm., grossly normal.
6. Kidneys 140 gm. each, grossly normal.
7. Spleen 128 gm., grossly normal.

Remainder of autopsy negative except for gallbladder calculi.

The biospy diagnosis was pulmonary adenomatosis. Figure 3 is representative of the histopathology in any of the consolidated lung parenchyma, in either lung. Note the adenomatous proliferation of well-differentiated columnar cells with abundant, pale, almost clear cytoplasm. The regular organoid pattern is due to these neoplastic columnar cells lining up on the alveolar septae of the lung, thus not distorting the normal bronchiolar-alveolar architecture. The nuclei are oval, vesicular, hyperchromatic, and quite uniform. Some show one or two nucleoli, but mitotic figures are rare. The cytoplasm is finely granular to clear and stains pink to red with mucicarmine stain. The majority of alveoli are lined by a single layer of these secretory columnar cells, but here and there they are multilayered or pseudostratified. Focal areas of atypical epithelium can be found in which nuclei have lost their polarity and show condensations of chromatin and more mitoses. On close inspection, it is seen that some of these neoplastic cells are ciliated, especially where terminal bronchioles merge with pulmonary alveoli. In some sections one can demonstrate continuity between tumor cells lining alveoli and the epithelium of respiratory bronchioles. The exudate in alveoli and bronchioles also stains positive for mucin. Lung tissue not involved by the neoplastic process showed emphysema, areas of organizing pneumonitis, and mild bronchiectasis. The bronchi were filled with mucinous plugs and epithelial debris as in bronchial asthma, but no bronchial mucosal lesion was present anywhere. In areas of emphysema, the pulmonary arterioles were somewhat thickened. The hilar, peribronchial, and mediastinal lymph nodes showed no evidence of metastases of the lung tumor. Several contained old caseous or calcified nodules with no histologic evidence of activity. Gram, acid-fast, and fungus stains revealed no organisms. They are assumed to represent healed lesions of either tuberculosis or histoplasmosis.

The only significant histopathology outside the lungs was the tremendous hypertrophy of the right ventricle in a normal-sized heart (fig. 4), and evidence of chronic passive congestion in the liver, though the gross appearance was not impressive.

In summary, the major pathologic diagnoses in this case are:

1. Bronchiolar or alveolar cell carcinoma of the lung (diffuse type)
2. Pulmonary emphysema
3. Pulmonary arteriolar sclerosis
4. Right ventricular hypertrophy with chronic cor pulmonale
5. Chronic passive congestion of the liver.

Clinical Discussion and Correlation

Doctor Burich: I certainly accept the pathologist's diagnosis, and only wonder why I didn't give serious consideration to this special lung neoplasm. In retrospect, one of the major clues should have been the copious amounts of tenacious, mucoid, white sputum. The mottled, atypical, bilateral, pulmonary infiltrate without a bronchial lesion should have aroused some suspicion. Did the radiologist ever seriously consider this diagnosis?

Doctor Bruder: No, I didn't. Interestingly, my reports unknowingly describe this condition pretty well. The phrases "salt and pepper effect" and "tendency to nodularity" are quite classical in describing the x-ray appearance of bronchiolar carcinoma. The refractory pneumonitis without fever bothered me at the time of the 1946 film. I was thinking of lymphoma and sarcoidosis, but always felt there should be more conspicuous hilar and mediastinal adenopathy. I never considered tuberculosis very strongly for the same reasons Doctor Burich outlined. I did feel a pulmonary mycosis was a likely possibility and I believe mentioned that in one report. I think both a diffuse and a nodular type of this lesion are recognized, and of course mixed types must occur. Coalescent nodules make the diffuse type of involvement. This disease can be focal in one lobe or involve an entire lobe or parts of all lobes of both lungs. In this case, portions of three lobes were involved; and finally the disease was demonstrated in all lobes of both lungs.

Doctor Thorolf Gundersen: The relationship of "benign pulmonary adenomatosis" to bronchiolar carcinoma is probably worth mentioning, though they might represent stages of the same basic disease if all cases could be followed. Various authors have called attention to the morphologic similarity of pulmonary adenomatosis in man to a communicable disease in sheep called jagziekte. Attempts to transmit the disease from man to sheep have been unsuccessful. No virus has been isolated from sheep or man. The implication that infection must precede the development of pulmonary adenomatosis has little to support it. Most, I think, consider the lesion a neoplasm.

Doctor Jaeck: I might add that the terms benign and malignant as applied to this disease mean nonmetastasizing or metastasizing rather than difference in histologic characteristics. Even those tumors which have metastasized are so well differentiated they are indistinguishable from so-called benign pulmonary adenomatosis. Though our case showed no demonstrable metastases, foci of atypical epithelium and mitotic activity made us feel justified in calling this the diffuse type of bronchiolar carcinoma. It should be stressed that these tumors usually cause death by their effects on the lung or heart rather than by their metastases. Chronic cor pulmonale with right heart failure is often the cause of death in either extensive pulmonary adenomatosis or the diffuse type of bronchiolar carcinoma. Secondary pneumonia causes demise in some cases.

Dr. J. Harmon: How do you know this isn't metastatic tumor in the lungs?

Doctor Jaeck: A very proper question, Doctor Harmon. There have been cases in point, both clinical and pathological, chiefly when the lesion is of the nodular type, involving several lobes. Of course, exclusion of other primary sites of carcinoma by thorough autopsy examination is the obvious answer; but small primary tumors have been missed. Mucin-producing adenocarcinomas in the lung, either metastatic or primary, may have all the histologic features of bronchiolar carcinoma except for one, the presence of ciliated tumor cells.

Bronchiolar carcinoma is distinguished from bronchiogenic carcinoma by the following characteristics:

1. Absence of bronchial stenosis or obstruction
2. Progressive and extensive parenchymal involvement
3. Usually bilateral
4. Peripheral location
5. Slowness to metastasize
6. Associated right heart failure
7. Multicentric origin
8. Benign histologic appearance

Doctor Aksness (intern): Doctor Jaeck has asked me to summarize eight autopsied cases of bronchiolar carcinoma from the literature. Three of these were classified as benign adenomatosis, three as malignant (bronchiolar carcinoma), and two as benign with malignant changes without metastases. The correct clinical diagnosis was not made in any of the eight cases. The most common clinical findings were dyspnea, cough, weight loss, and peripheral edema. Only one patient had thick mucoid sputum, but there was abun-

dant mucin in bronchioles and alveoli at autopsy. Pain, fever, and hemoptysis were infrequent symptoms.

Dr. C. F. Midelfort: How consistent are cytologic studies of secretions in bronchiolar carcinoma?

Doctor Jaeck: Most reports admit a poor percentage of correct cytologic diagnoses for this neoplasm as compared to the percentage for any histologic type of bronchiogenic carcinoma of the lung. This likely is due to the high degree of differentiation of cells exfoliated in bronchiolar carcinoma and adenomatosis. This neoplasm comprises only 2 to 5% of all primary lung tumors. What is the surgical aspect of treatment of this tumor, Doctor Burich?

Doctor Burich: I think for focal or unilateral disease, excisional surgery is the only hopeful treatment. The diagnosis should be established by sputum or biopsy before resectional surgery is done. In view of the peculiar growth characteristics and manner of spread, conservative pulmonary resection would seem to be the treatment of choice for most cases. As yet there have not been enough cases so treated to permit five-year follow-up studies. Certainly, without surgery this lesion appears to be slowly progressive and fatal. Unfortunately, by the time symptoms appear, the disease is quite widespread in the lungs.

REFERENCES

1. Liebow, Averill: Tumors of lower respiratory tract, in Armed Forces Institute of Pathology: Atlas of Tumor Pathology, Section V, Fascicle 17, 1952.
2. Storey, C. F., Knudtson, K. P., and Lawrence, B. J.: Bronchiolar ("alveolar cell") carcinoma of lung, J. Thoracic Surg. 26:331–406 (Oct.) 1953.

THESE GUIDES MAY HELP YOU

The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
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14. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.

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"To Everything There Is a Season . . ."

The words of Ecclesiastes have a poignant meaning as the theme of the first Governor's Conference on an Aging Population, June 6 to 8 in Madison. More than anyone else, perhaps, the physician sees and knows the problems that come with the aging process.

Physicians must take a vital role in the Governor's Conference in June, not simply because a large part of the program is related to health aspects of the care of the aged, but because elderly citizens turn to physicians for guidance when their own means fail them. With so large a group expecting so much from the physicians of Wisconsin, the doctors of medicine must utilize every opportunity to keep abreast of thinking in this important area of health care and human relationships.

A special invitation has been extended by the Division on Geriatrics of the State Medical Society to all physicians for their attendance at an all-day session on Thursday, June 7, relating to "The Role of the County Medical Society in the Care of the Aging." George G. Stebbins, M. D., Madison, will serve as chairman of the session. He will have the assistance of two other physicians, two social workers, a visiting nurse, and a private nursing home operator.

County medical societies throughout the state are finding themselves projected into community-wide efforts for dealing with the aged. This session can be of substantial guidance to physicians in outlining their responsibilities and methods of approach to local situations. Interested physicians are urged to attend; and, of course, county societies are urged to designate official representatives for this important conference.

The State Medical Society of Wisconsin has played a major role in the development and promotion of the Governor's Conference through the efforts of Adolph M. Hutter, M. D., Fond du Lac, chairman of the Society's Division on Geriatrics. Each member of the Division has been asked by the Governor to participate in one of the workshop sessions of the conference relating to health.

Here are some of the discussions in which physicians have been invited to participate:

Home Care for the Aging and Long-Term Patient
State Services: Their Scope and Content
The Team Approach to the Care of the Aging
Care of the Senile
Essentials of a Community Plan for the Aging
Education For and About the Aging.

Physicians have a most important place at this conference. They have much to give as well as receive, since the conference is designed primarily for those whose professional work is with the aged.

Dr. L. O. Simenstad, new State Medical Society president, was born in Northwood, North Dakota, on September 26, 1900. He received his medical degree from Rush Medical College, Chicago, in 1924 and served his internship at Ancker Hospital, St. Paul. A general practitioner and surgeon, Doctor Simenstad practices at Osceola.

He was one of the organizers of the Polk County Medical Society and has been a president of the group. Other capacities in which he has served include president of the Tenth Councilor District, member of the State Society's Council on Medical Service, member of the House of Delegates, speaker of the House, and alternate delegate to the American Medical Association.

He is a Fellow of the American College of Surgeons and the International College of Surgeons and a member of the World Health Organization and the Industrial Medical Association. At Ladd Memorial Hospital, Osceola, he serves as chief of staff.

Society Proceedings

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met with 25 Green Bay attorneys on March 8 at the Elks Club in Green Bay.

Speakers at the meeting were *Dr. J. C. Griffith*, Milwaukee, and Mr. N. C. Skogstad, Milwaukee. They discussed the Interprofessional Code, a joint service publication of the State Medical Society and the Wisconsin Bar Association. After the addresses, a question-and-answer period was held, and many interprofessional problems were clarified.

A short business session was held. Mr. John Reynolds, Jr., a Green Bay attorney, offered two scholarships on behalf of the United Cerebral Palsy of greater Green Bay. The scholarships are to be used for two weeks' post-doctoral study of newer developments in the treatment of cerebral palsy under Dr. M. A. Perlstein, Cook County Graduate School of Medicine, Chicago.

Fond du Lac

Dr. M. Lustok, Milwaukee, addressed the Fond du Lac County Medical Society on March 22, and chose as his subject "The Management of Coronary Heart Disease and its Complications." The meeting was held at the Elks Club in Fond du Lac.

Kenosha

The Kenosha County Medical Society held a joint meeting with the Kenosha Bar Association on April 5 at the Elks Club, Kenosha.

A panel discussion of medical and legal problems was given by *Drs. David Goldstein* and *C. Sattler*, and attorneys Leo Vaudreuil and W. Sheldon. An open discussion period followed. Forty-two physicians and 29 attorneys attended the meeting.

Manitowoc

Nineteen members of the Manitowoc County Medical Society met March 29 at the Hotel Manitowoc in Manitowoc. *Dr. Henry Suckle*, Madison, addressed the group. He chose as his topic, "Head Injuries."

Outagamie

Forty members of the Outagamie County Medical Society met on March 15 at the County Hospital in Appleton.

"Modern Psychiatric Methods" was the topic of an address given by *Dr. J. T. Petersik*. Doctor Petersik is the director of the Winnebago State Hospital. A question–and–answer period followed his talk.

A short address was given by *Dr. J. B. MacLaren*, Appleton, on the needs and planned expansion of the Outagamie County Hospital.

Pierce–St. Croix

The Pierce–St. Croix County Medical Society was addressed by Dr. Brian McGroarty, St. Paul, at its March 20 meeting held at Hudson, Wisconsin. His topic was "Urinary Tract Infections."

Mr. W. C. White, Assistant Secretary of the State Medical Society, also spoke to the group, discussing Blue Cross coverage.

Seventeen members were present at the meeting.

Polk

At a dinner meeting of the Polk County Medical Society, February 16, Dr. Bradley W. Kusske of St. Paul presented a paper on "Problems Confronting the General Practitioner in Ear, Nose and Throat." A round-table discussion followed his address.

The society members were the guests of *Dr. W. A. Fischer*, Frederic, at Paradise Lodge in Balsam Lake. Eighteen members attended the meeting.

In a business session which followed the dinner and scientific address, the society approved the state-sponsored O.A.A. plan; and the president and secretary were directed to make a survey of the public immunization program and report their findings to the society.

Sauk

The Sauk County Medical Society met March 13 at the Warren Hotel in Baraboo. *Dr. Karver L. Puestow*, Department of Medicine, University of Wisconsin, spoke on "Treatment of Geriatric Problems."

In a business session which followed, the County Board Liaison Committee reported on the fee schedule for care of county patients. Sixteen members of the society were in attendance at the meeting.

Trempealeau–Jackson–Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the Club Midway, east of Independence, on March 20. Wives of members of the society were invited to the meeting as guests.

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Notes on the Diagnosis and Management of "Dizziness"

III. Ménière's Syndrome

1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*

2. Subtotal Hearing Loss. *Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.*

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*

Fewer diagnostic errors[1] will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization[2] by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

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It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

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1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.
2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.
3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., *141*:500 (Oct. 15) 1949.

A new edition of "Dramamine Reviews and Abstracts," containing digests of more than 100 recent articles, is available on request to . . . SEARLE P. O. Box 5110, B Chicago 80, Illinois

Waupaca

Mr. H. Johnson of the County Department of Public Welfare was the guest speaker at the dinner meeting of the Waupaca County Medical Society on March 22. The meeting was held at the Elmwood Hotel in New London.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine held its March meeting at the University Club of Milwaukee on March 20.

The principal speaker at the dinner program was Dr. Nathan S. Kline, Director of Research, State of New York, Department of Mental Hygiene, Rockland State Hospital, Orangeburg, New York. He discussed "The Psychiatric Use of Reserpine and Chlorpromazine."

On April 24 the group heard Dr. William H. Beierwaltes, Department of Internal Medicine, University of Michigan Medical School, speak on "The Diagnosis and Treatment of Hyperthyroidism." This meeting was also held at the University Club, Milwaukee.

Milwaukee Oto-Ophthalmic Society

The March dinner meeting of the Milwaukee Oto-Ophthalmic Society was held at the University Club of Milwaukee on March 27. *Dr. B. A. Waisbren,* Milwaukee, headed the scientific program, and spoke to the society on "The New Drugs."

First Councilor District

Forty physicians of the First Councilor District met recently at the Green Bowl in Watertown. Doctors from Dodge, Waukesha, and Jefferson counties medical societies attended the meeting.

In the business session, Mr. Robert Murphy, Madison, legal counsel for the State Medical Society, and Mr. Charles Crownhart, State Society secretary, spoke on social security and its significance to the medical profession.

Other business matters at the meeting, which was presided over by *Dr. William James,* Councilor from the First District, included a discussion of the Blue Cross–Blue Shield program relative to changes in the plan for the state in the future.

Wisconsin Surgical Club

The annual spring tour of the Wisconsin Surgical Club members and guests started in Chicago, March 11.

The group travelled to Creighton University Medical School, where they were entertained by Dr. H. H. McCarthy. A series of exhibits and demonstrations emphasized the research program of the institution. At the University of Nebraska, Dr. Herbert Davis and his surgical staff acted as hosts to the group.

Two days of the tour were spent at the Mayo Clinic. As guests of the surgical staff there, the group was served a dinner at the University Club, and a luncheon at the Foundation Home.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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The tour was completed at Iowa City at the University of Iowa Medical School. Here Dr. R. T. Tidrick, Chairman of Surgery, presented a program of surgery, conferences, and lectures. The week's tour ended with a dinner at a local restaurant in Iowa City.

International College of Surgeons, Great Lakes Division

The Great Lakes Division of the International College of Surgeons held its regional meeting at the Hotel Loraine, Madison, April 26–28.

Dr. Arnold S. Jackson, Madison, president of the United States section of the College, served as chairman of the arrangements committee for the meeting.

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"How to look at a doctor's bill" could well serve as the title for recent Parke-Davis advertisements on the cost of medical care. For they suggest to the public new ways of looking at the extraordinary *value* one buys with each dollar spent for prompt and proper medical care.

These Parke-Davis messages talk in everyday language about familiar but "forgotten" facts. Some examples: the steadily decreasing cost of curing diseases such as pneumonia, the phenomenal reduction in the death-rate for children, the substantial savings in time and income because of the shortened duration of hospital stays.

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News Items and Personals

Doctor Williams Named to Advisory Post

Dr. L. P. Williams, Appleton, was recently named by the Outagamie County Medical Society to act as delegate to the advisory committee of the county board's health committee. *Dr. J. L. Benton* of Appleton will serve as alternate.

The appointments were made at the request of the health committee, which asked for an official delegate to the advisory board from both the medical and dental societies.

Doctor Hunter Attends Postgraduate Meeting

Dr. and Mrs. *Richard Hunter*, Argyle, recently went to Washington, D. C., where Doctor Hunter attended a national postgraduate medical meeting. The meeting was sponsored by the American Medical Academy.

Doctor Cook Leaves Menomonie

Dr. Frederick D. Cook, who has been with the Red Cedar Clinic at Menomonie since 1950, recently moved to Madison. He is entering a residency in anesthesia at the University of Wisconsin Medical School. After completion of the two-year course, Doctor Cook will confine his practice to the administration of anesthesia.

Doctor Meyer Is Guest Speaker at Elm Grove P.T.A.

Dr. Julius Meyer, specialist in internal medicine in Milwaukee, was recently the guest speaker at the Dixon School P.T.A. at Elm Grove. He chose as his topic, "Stop Rheumatic Fever." Pamphlets on this subject were also distributed.

Doctor Hammes Speaks at Marriage Forum

Dr. G. R. Hammes, Wausau, recently addressed the fourth marriage forum session in Wausau. He discussed "The Physical Aspects of Marriage," and "What a Doctor Can Tell You About Marriage." Doctor Hamme's specialty is obstetrics and gynecology.

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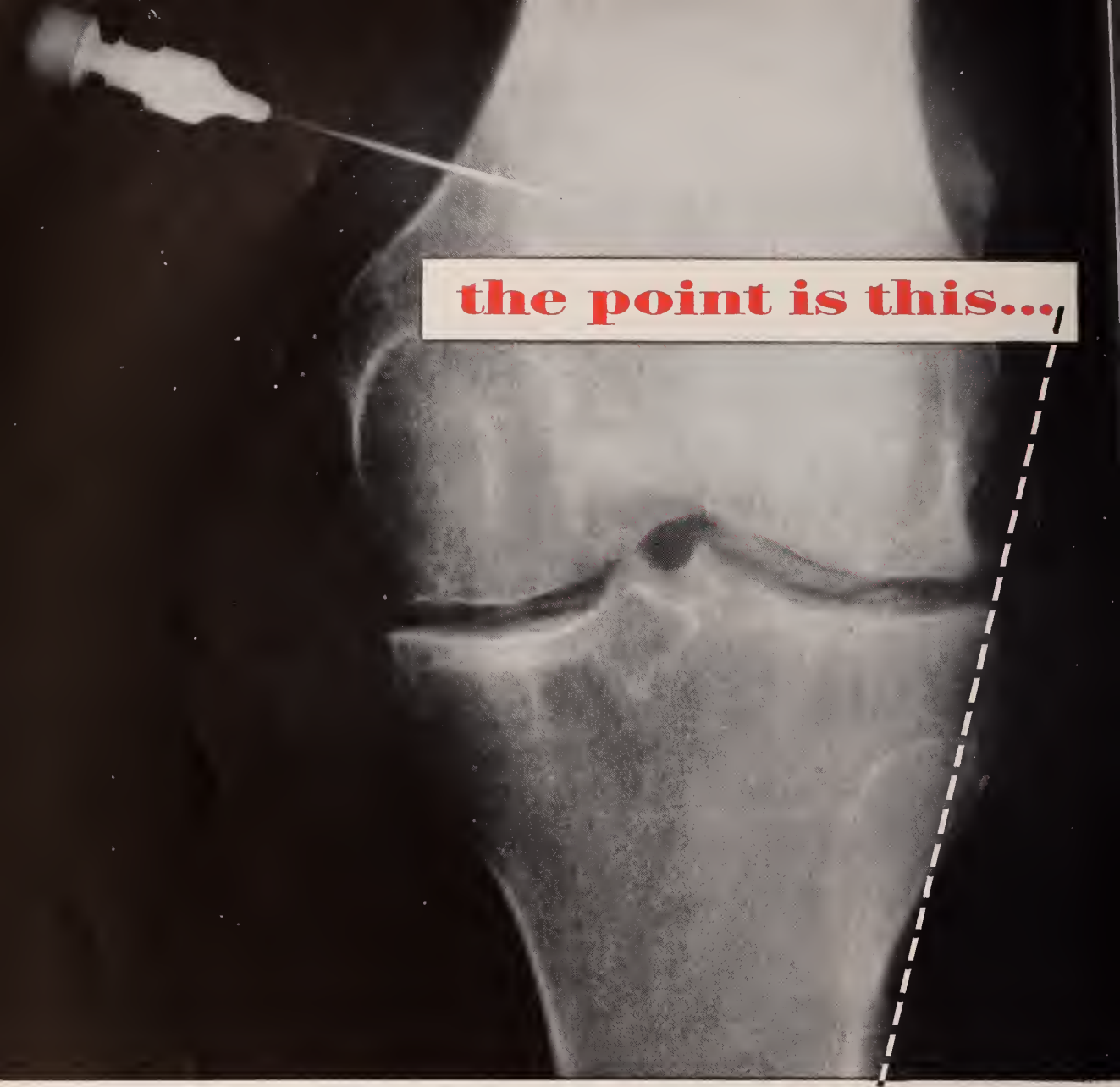

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THIRD AND TWELFTH DISTRICTS NEWS

Doctor Curreri Speaks in Jefferson

Dr. Anthony Curreri, associate professor of surgery and director of the Tumor Clinic at the University of Wisconsin, was the guest speaker at the annual founder's day dinner of the Jefferson Wisconsin Alumni Association. The dinner was held at Meadow Springs, March 29.

Doctor Campbell Attends Medical Meetings

Dr. R. E. Campbell, Madison, recently attended the District IV meeting of the American Academy of Obstetrics and Gynecology at Washington, D. C. Doctor Campbell, who is president of the Academy, will also travel to Tucson for the meeting of District VIII and then to Minneapolis, where he will preside at the District VI meeting.

Dr. C. G. Reznichek Attends Academy Meeting

Dr. and Mrs. *C. G. Reznichek*, Madison, recently traveled to Washington, D. C., where Doctor Reznichek attended sessions of the Academy of General Practitioners. Doctor Reznichek is former Wisconsin president of the Academy.

Doctor Lawrence Appointed to Kenosha County Post

Dr. Paul Lawrence, who for the past six years has been the assistant medical director of the Lakeview Sanatorium in Madison, will assume a new position at the Willowbrook Sanatorium in Kenosha. His new position with the Willowbrook Sanatorium will be that of county physician.

Doctor Wilkie Named Consultant at Pinehurst Sanatorium

Dr. James Wilkie, medical director of the Morningside Sanatorium in Madison since 1947, recently accepted the position as new tuberculosis consultant at the Pinehurst Sanatorium in Janesville. He will have charge of the out-patient department, x-ray work, and clinics at Pinehurst.

U. W. Doctors Speakers at Postgraduate Course in Madison

Dr. Marc J. Musser, professor of medicine at the University of Wisconsin, addressed a group of doctors attending a postgraduate course in internal medicine held in Madison on March 21.

Doctor Musser stated that in many cases physical illnesses are actually caused by underlying emotional disturbances and that symptoms of psychosomatic illnesses are often difficult to diagnose since physical manifestations may occur without clear-cut evidence of emotional difficulty.

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John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
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LAKESIDE

Doctor Charles W. Crumpton, Director of the Cardiovascular Research Laboratory at the University of Wisconsin also addressed the group. He stated that choosing the proper dose of the proper drug for each patient is the most important single factor in medical treatment of hypertension.

Madison Education Association Addressed by Doctor Bowers

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, was the guest speaker at the annual banquet of the Madison Education Association held at the Memorial Union, Madison, on March 13. Dean Bowers spoke on "Your Health and You."

SOCIETY RECORDS

New Members

M. W. Asplund, Bloomer.

R. D. Gibson, West Bend.

Allen Misch, 204 North Washington Street, Cedarburg.

L. A. Kristensen, Chetek.

C. B. Nash, 508 West Milwaukee Street, Janesville.

J. C. Trautmann, Prairie du Sac.

J. D. Weinstein, 5201 West Center Street, Milwaukee.

R. L. Smith, 8700 West Wisconsin Avenue, Milwaukee.

R. W. Stockton, 321 Holum Street, De Forest.

T. N. Thompson, Jr., Neillsville Clinic, Neillsville.

Roger E. Laubenheimer, 425 East Wisconsin Avenue, Milwaukee.

J. M. Sorenson, 6254 North Port Washington Road, Milwaukee.

James H. Barbour, Green Lake.

W. G. Locher, Box 304, Wausau.

A. J. Venables, 808 Third Street, Wausau.

L. E. Schmidt, 316 Ruder Street, Wausau.

W. C. Hill, 103 West College Avenue, Appleton.

Elizabeth Kundert, Professional Building, Eau Claire.

L. E. Hughes, 314 East Grand Avenue, Eau Claire.

R. H. Troup, Eagle River.

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Changes of Address

D. D. Ruehlman, Monroe, to 5825 Sixth Avenue, Kenosha.

H. R. Foerster, Jr.,** Detroit, to 208 East Wisconsin Avenue, Milwaukee.

F. D. Cook, Menomonie, to 413 Midvale Boulevard, Madison.

M. J. Ciccantelli, Wood, to 630 South 10th Street, La Crosse.

H. M. Stang, New Auburn, to 1836 South Avenue, La Crosse.

E. E. Skroch,** Camp Pendleton, California, to 1912 Atwood Avenue, Madison.

L. J. Kreissl,** Oakland, California, to 2302 Grace Drive, Santa Rosa, California.

H. L. Burdick,** Randolph AFB, Texas, to Milton.

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THE MEDICAL FORUM

HOUSE BACKS STATE CONFERENCE ON PROBLEMS OF AGING

Milwaukee—Here are some of the major actions of the State Medical Society at its Annual Meeting here May 1–3:

Authorized an investigation of cancer quackery in Wisconsin.

Gave enthusiastic backing to the upcoming Governor's Conference on Problems of An Aging Population in Madison June 6–8, and urged Wisconsin physicians to attend.

DOCTOR-CORONERS

Urged physicians to run for the office of coroner.

Ordered a thorough study of relations between physicians and hospitals.

Opposed licensing of clinical psychologists on the basis they are not trained in the medical sciences.

Created a Division on Diabetes under the Commission on State Departments.

CAR SAFETY CONSIDERED

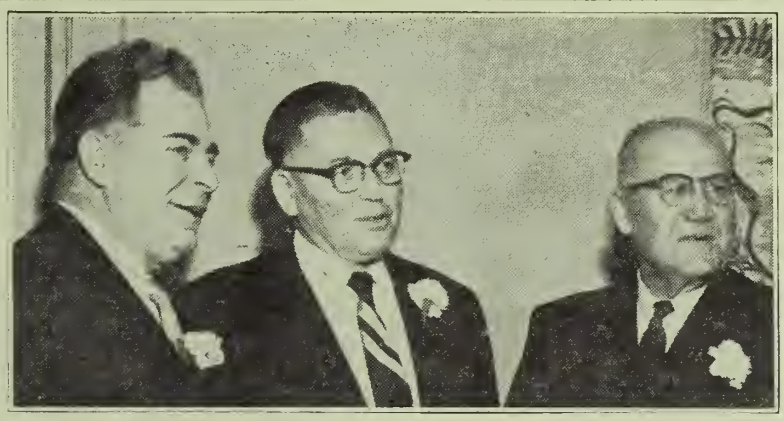
Advocated a campaign calling for all Wisconsin physicians to install safety belts in their automobiles.

Reelected **Dr. T. W. Tormey, Jr.**, Madison, general chairman of the Commission on State Departments, and named the following division chairmen:

Drs. H. A. Anderson, Stevens Point, Tuberculosis and Chest Diseases; *G. S. Kilkenny,* Milwaukee, Maternal and Child Welfare; *Maxine Bennett,* Madison, Visual and Hearing Defects; *H. A. Sincock,* Superior, Crippled Children; *E. H. Pawsat,* Fond du Lac, School Health; *R. W. Boyle,* Milwaukee, Rehabilitation; *A. M. Hutter,* Fond du Lac, geriatrics; *H. W. Carey,* Lancaster, Public Assistance; *E. D. Schwade,* Milwaukee, Nervous and Mental Diseases and *R. S. Gearhart,* Madison, Safe Transportation.

COMMITTEE NAMED

Selected **Drs. E. L. Bernhart,** outgoing president, and **R. E. Galasinski,** Milwaukee and **J. M. Bell,** Marinette, for positions on the Council's Executive Committee.



PAST, PRESENT AND FUTURE—as presidents of the State Medical Society of Wisconsin are the above gentlemen. Caught chatting at the Annual Meeting of the Society in Milwaukee in early May were the immediate past-president, *Dr. Ervin L. Bernhart* of Milwaukee (left); the newly-installed president, *Dr. L. O. Simenstad,* Osceloa (center), and *Dr. Harry E. Kasten* of Beloit, who was named president-elect. The carnations show the doctors were in attendance at the Past-Presidents' Luncheon. *(Photo by Taylor, Milwaukee)*

Dr. Kasten Named President-Elect

Milwaukee—The State Medical Society's 102nd president will be **Dr. Harry E. Kasten** of Beloit.

The House of Delegates, at the Society's 115th Annual Meeting here May 3, selected Dr. Kasten, a urologist and dermatologist, as president-elect, to succeed **Dr. L. O. Simenstad,** Osceola, who took over the organization's top post at the same time. Dr. Kasten will take office in May, 1957.

Dr. J. W. Fons, of Milwaukee, was renamed Speaker of the House, and **Dr. W. B. Hildebrand,** Menasha, selected as vice-speaker. Elected again as delegates to the American Medical Association were **Drs. S. E. Gavin,** Fond du Lac; **D. H. Witte** and **J. C. Griffith,** Milwaukee. These alternates were named: **Drs. Simenstad; E. L. Bernhart,** the outgoing president, and **R. E. Galasinski,** Milwaukee.

Reelected to the Council were:

Drs. J. C. Fox, La Crosse, seventh district; **J. M. Bell,** Marinette, eighth; **R. E. Garrison,** Wisconsin Rapids, ninth and **R. G. Arveson,** Frederic, tenth. **Drs. J. D. Leahy,** Park Falls, and **J. E. Conley,** Milwaukee, were newly-elected councilors.

Foundation Reelects Dr. Bernhart President

Milwaukee—**Dr. E. L. Bernhart,** Milwaukee, immediate past-president of the State Medical Society, was reelected president of the *Charitable, Educational and Scientific Foundation Inc.,* of the Society at the Annual Meeting May 1.

Dr. Arthur J. McCarey, Green Bay, was renamed vice president of the Foundation to succeed **Dr. H. Kent Tenney** of Madison. Drs. McCarey and Tenney are past-presidents of the Society.

This was the first annual meeting of trustees of the Foundation which was created in 1955 to develop financial support for a variety of medical problems for which no other funds are available.

Special State Meeting June 6–8 to Study Problems of Aging Population

Madison—Wisconsin medical authorities will join forces with others interested in problems of geriatrics at a special **Governor's Conference on Problems of An Aging Population** here June 6–8.

"This should be a most worth while, informative gathering," **Dr. Adolph M. Hutter,** Fond du Lac, chairman of the State Medical Society's Division on Geriatrics, commented.

URGE PHYSICIANS TO ATTEND

"We would like to see a large number of Wisconsin physicians in attendance. They can contribute much, and also become better informed on the problems, the trends and needs of our older people. This conference is being held for the first time in Wisconsin, and will pin-point many of the things that should be of concern to all of us."

Dr. Hutter and **Dr. Allan Filek,** of the State Board of Health, are members of the Conference executive committee.

S. M. S. - SPONSORED

The State Medical Society is one of the Conference sponsors.

Expected to take an active part in the sessions are a number of Wisconsin physicians, including **Dr. Carl N. Neupert,** State Health Officer; **Millard Tufts and Owen Otto,** Milwaukee; **Dr. N. A. Hill, Dr. Leslie A. Osborn, Dr. George G. Stebbins,** of Madison, and **Dean John Z. Bowers, M.D.,** of the University of Wisconsin Medical School.

Five of 14 workshops June 7 will be devoted to medical and health care. These include sessions on "Role of the County Medical Society in the Care of the Aging"; "Care of the Senile"; "The Team Approach to the Care of the Aging"; "Home Care for the Aging and Long-term Patients" and "Public Health Services in Nursing Home Care."

KOHLER TO SPEAK

Dr. Alfred Kraft, of Allegheny Institutions, Pittsburgh, and Wisconsin Gov. Walter J. Kohler will be the keynote speakers at the opening session. Other speakers will include Dean Bowers and Dr. Jack Weinberg of Chicago.

Annual meetings of the **Wisconsin Public Health Council Inc.,** and the **Wisconsin Association for Public Health,** on June 5, will be held in Madison in conjunction with the Conference.

Dr. Hutter

PURPOSEFUL SESSION

The Conference was planned months ago to bring together interested persons for an exchange of ideas and experience; to acquaint others, including the public, with community programs and work accomplished in the field of aging; to present the newest facts and findings in the field, and to make recommendations on what can be done on state and local levels.

The third day of the Conference will be devoted to reports of workshops and recommendations for future activity.

The meetings were arranged for persons already in their later years, those preparing for that period, those engaged in providing services for the aged, and those who in their work deal with or are concerned with older persons.

SUBJECTS EXTENSIVE

Areas to be discussed include medical and health care, community planning, education, use of leisure time, the older worker, economic security, the church and the older person, group living and care, housing, laws-legislation and policy, and community contributions by the aging.

Gov. Kohler commented:

"Finding solutions to the many problems confronting our senior citizens is of utmost importance in the advancement of human happiness."

Officials said the Conference would stress the fact Wisconsin's over-65 population is greater than the national average, that there are few approved roles for the older residents in society, and the great necessity for keeping informed on current and developing problems of the aged.

Dr. Stovall Explains 7-County Cancer Smear Testing

Madison—"The Doctor's Office—A Detection Center for Cancer."

That is the theme of a seven-county Papanicolaou smear-test project to be conducted late this spring, with physicians in each area sponsoring the program.

Dr. William D. Stovall, Madison, director of the State Laboratory of Hygiene, addressed members of the State Medical Society on **General Practice Day, May 1,** during the organization's Annual Meeting in Milwaukee. He explained how the tests on selected women represent an excellent opportunity for diagnosis for general practitioners.

WORK WITH U. S. P. H. S.

Dr. Stovall said the laboratory is working together with the **U.S.** Public Health Service, financial sponsor of the program, in planning details relative to the activity.

"The Public Health Service," Dr. Stovall said, "was anxious to do this survey in Wisconsin in order to widen the scope of the activity which we are able to carry on with our own staff to gain certain information concerning the matter of carcinoma in situ, to obtain statistics on the incidence of cancer in these areas, to emphasize the importance of this test to women of this area and lastly, to encourage doctors, particularly in rural areas, to use the test."

INSTRUCTIONS SUPPLIED

He added:

"Doctors will be supplied with all of the equipment for collecting the smears and properly preparing them for shipment to our laboratory for examination. Instructions will go out with each mailing carton with full details as to how the smears are to be made, how they are to be fixed and returned."

S. M. S. - APPROVED

The program was approved by the **Council of the State Medical Society,** by the State Board of Health and the University of Wisconsin Medical School authorities.

Physicians with questions relating to the smear tests are urged to write Dr. Stovall in Madison.

PLATTEVILLE—This is a scene of the April 12 Conference on School Health at Wisconsin State College in Platteville. One of the workshops, on *Special Health Problems Including Nutrition and Dental Health*, is busy at work above, with Dr. George R. Barry, of Monroe (in light suit), as moderator. The resource person, Dr. J. W. Conklin, Platteville, is at right rear. Other panel members were Walter J. Ploetz, superintendent of Platteville public schools; Leo Boebel, Platteville PTA member; L. E. Fitzgerald, D. D. S., Darlington; Martha Henry, Dist. 1 nutritionist for the State Board of Health; Erna Mertz, Lancaster, Grant county nurse, and Elizabeth Terry, Baraboo, Sauk county nurse.

Schedule School Health Sessions at Whitewater, Superior

Madison—Whitewater and Superior will be the sites for Conferences on School Health next fall.

Part of a series of sessions under the direction of the State Medical Society's Division on School Health, the Conferences are expected to continue the trend of large, enthusiastic audiences. Dr. E. H. Pawsat, Fond du Lac, is Division Chairman.

DATES SET

The Whitewater meeting will be held October 18, the Superior one November 15. State Colleges in both communities will host the Conferences.

Dr. Edgar S. Gordon, of the University of Wisconsin Medical School, will speak at both meetings on *"The Integrated Physical and Emotional Growth of Children."* His talks have created much interest at previous gatherings in Platteville, Milwaukee, Madison, La Crosse, Medford, Oshkosh, Stevens Point and Eau Claire.

TOPICS VARY

Workshops are held on various topics. A Platteville conference on April 12 conducted panels on *"Health Examination of Pupils and School Personnel,"* "Special Health Problems Including Nutrition and Dental Health," "Health Aspects of Physical Education," *"Putting Preventive Mental Health Concepts to Work in the School"* and "Referral and Treatment of Pupils with Emotional Problems."

"MOST WORTHWHILE"

C. O. Newlun, president of Wisconsin State College, Platteville, said the conference was *"most worth while, and made us fully aware of the importance of health care in our schools."*

Nearly 3,800 teachers, parents, physicians, dentists, public health workers and others have turned out for the previous conferences.

Madisonians Get Brief Scare—Human Bones!

Madison—For a few days, some folks in Madison had visions of a mystery of murderous proportions after a number of human bones was found in a basement.

Detective work followed. The bones, from a woman's hand, arm and shoulder, were traced to a former University of Wisconsin Medical School Student, **Dr. William Seiliger**, who is practicing in Ogden, Utah.

Reached by phone, Dr. Seiliger said he forgot the bones after using them in an anatomy class.

The bones were returned to the Medical School.

Case closed.

Ford Grants $10 Million For Medical Education

New York—To stimulate interest and support for America's medical schools, the Ford Foundation has allocated $10,000,000 to the National Fund for Medical Education.

Grants from the appropriation will be paid on a matching scale in a program of five to 10 years' duration, depending upon the rate at which the National Fund develops additional support for both public and private medical schools. The maximum grant in any one year would be $2,000,000.

The new grant is apart from the $90,000,000 appropriation announced by the Foundation last winter to help privately-supported medical schools strengthen their instruction.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE policies are not terminated nor are benefits reduced because of age.

T·I·C·

TIME

INSURANCE COMPANY

MILWAUKEE WISCONSIN

MICHIGAN STIRRED BY PROPOSED BLUE CROSS RATE HIKE

Detroit Times, Free Press Defend, Question Current Policies and Rates

Detroit—The Blue Cross, an editorial in the Detroit Times stated, "*is getting a vicious and needless pushing around.*"

Another editorial, in the Detroit Free Press, said that physicians, through their dealings with patients and because they control both the hospitals and the Blue Cross organization, "*have failed, in our estimation, to take an active public stand on the abuses*" under the voluntary hospitalization insurance plans.

Both editorials represented reactions to a current squabble over a proposed rate boost. They appeared in late February.

The *Times* editorial:

"We didn't suspect a week ago today, when we started a series of articles on Blue Cross, that the fuss over hospital prepayment would attain the intensity it now has reached.

"**The amount of hullabaloo, frankly, is getting out of hand.**

NO "CURE-ALL"

"Rep. Allison Green has a bill for the Legislature, which he fondly hopes will solve everything. It won't.

"Insurance Commissioner Joseph A. Navarre has been quoted with some remarks which we suspect he will regret when he begins to realize what he has said.

> "*A group of unions in Detroit and Flint is proposing to set up a rival 'Blue Cross plan,' which is entirely within their rights, even though we doubt it will look as simple to them once they have gotten into what is a very complicated problem.*

"Of the three—Rep. Allison, Commissioner Navarre, and the unions—we think the unions are behaving most reasonably. We differ with them only in our opinion as to whether they CAN produce what they think they can.

"But of the whole lot, we think Blue Cross and its present managers are the most capable of providing what we want. **We think Blue Cross is getting a vicious and needless pushing around.**

"But this is the editorial page, and this is our opinion, and we are saying what we think.

OVER-USE DENIED

"**Why do we think "over-utilization" is not as great as some people try to suggest?**

"**First,** because a Blue Cross study group itself was the first to dig into the matter. No attempt to hide anything. Just an effort to correct the situation, since chiseling by one subscriber is paid for by all the honest ones.

"**Second,** Blue Cross, by subsequent and continuous inquiry, thinks that this evil is under good control, even though there is still an occasional violation.

"If the plan here happened to be at fault, in some way, it is hardly possible that all the states would be at fault in the same way.

"**Somewhere in the country we would find that Blue Cross rates were markedly lower—we would find it, that is, if Michigan's Blue Cross were letting the customers get away with murder.**

"Somebody would have found a solution, and would be bragging about it. But no, rates are pretty comparable anywhere you go.

"Therefore, we suspect this '*over-utilization*' has been publicized into a bigger fault than it really is. We don't think very many people get much fun out of going to, or staying in, a hospital.

GREEN REFUTED

"*Now Rep. Green thinks he could bring about lower rates, and thwart all the chiselers (such as there are —most people are honest) by a law making Blue Cross change its policy.*

"*He would make everyone who uses Blue Cross pay the whole cost of the first day in the hospital (the most expensive day, because then you have all the tests, and usually the operation if you need one) and also pay 15 per cent of the cost after the seventh day.*

"Of course that would reduce the premium you pay for Blue Cross—but you'd soon find it didn't save any money. Furthermore, it would put the biggest burden on the people who are most seriously ill. Who wants that?

CHOICE ELIMINATED

"Rep. Green, with the best of intentions, has over-simplified the situation. Besides, he wants to make this *compulsory* for everybody—doesn't even want to give subscribers a choice of which way they'd rather do it.

"**Commissioner Navarre, for reasons which escape us, has indorsed Rep. Green's notion. We suspect some politics somewhere, because we think Navarre ought to know better.**

"To get back to the unions, now. They'd like a policy which gives more benefits at lower cost. Who doesn't like the idea? Who doesn't want the good five-cent cigar back, or the $700 automobile or the three-cent newspaper, for that matter? We'd like them all back.

"**But you can't slap economics in the face.**

"**You can't legislate Utopia.**

"And so far as we are concerned, you can't say that Blue Cross hasn't been doing a good job.

PRICES IN LINE

"Its prices haven't gone up any faster than factory wages. It has been so good that it now has 3,600,000 people, or half of the whole state, using Blue Cross and liking it.

"*We think, flatly, that Blue Cross is a fine thing, and we hope all the noise won't fool the people and unduly alarm them.*

"Blue Cross is merely a victim of our rising economy just as everybody else is."

Under the heading, "Trying to Spot the Real Villain," THE FREE PRESS said:

RATES UNFAIR?

"Old melodramas had their advantages. It was easy to identify the villain. This is not so in the current uproar about hospitalization insurance. Rates have skyrocketed. Many think Blue Cross has thrust its hand too deeply into the pockets of its 3,600,000 Michigan subscribers. Investigations are being made, bills are being submitted to the legislature, and the air is blue with charges.

(Continued on page 574)

Administration Voices Strong Dislike of H.R. 7225 Social Security Proposal

Washington—The Eisenhower administration came out in early April with a clear-cut stand on the controversial social security bill, H.R. 7225.

It approved extension of coverage, but opposed reduction of retirement age for women and payments for disability.

This position was presented to the Senate Finance Committee by **Secretary Marion B. Folsom of the Department of Health, Education and Welfare.**

Secretary Folsom declared:

"The American people owe a large debt to the committee for its decision to conduct extensive hearings."

Last year on the House side there were no hearings prior to passage of the measure.

The secretary said Congress "would be endangering rather than strengthening the program by enacting the provisions relating to reducing the retirement age and making payments for disability.

He testified:

SERIOUS PROBLEM

"We all recognize that prolonged and severe disability is indeed a serious problem for the individual, his family and the community. On the other hand, as the testimony before this committee has shown, there are serious differences of opinion about the wisdom of bringing the new element of cash disability payments into the old-age and survivors' insurance program.

"I believe the committee should carefully consider the need for the proposed change, its practicality, its long-range effects on the social security program, and its potential long-range costs."

On the section lowering the retirement age for women from 65 to 62, Mr. Folsom noted this would cost about 400 million dollars the first 12 months and more than one billion dollars a year by 1970. The proposal, he said, *"has been considered several times in the past 20 years, but Congress always has concluded that any overall values of a lower retirement age were outweighed by the heavy cost. And there has been a serious question as to the logic of a discrimination in retirement age between men and women."*

The Eisenhower administration favors extending OASI coverage to such self-employed as lawyers, dentists, osteopaths, optometrists and veterinarians, and to military and civil service personnel.

To Survey U. W. Medical Center

Madison—As a move to improve its services, the University of Wisconsin Medical Center will be surveyed by a Minneapolis hospital consulting firm this summer.

The U.W. Board of Regents in April approved a $25,000 contract with James A. Hamilton Associates for a six months' study.

EVALUATION SOUGHT

Dean **John Z. Bowers** of the Medical School said the survey would be directed toward evaluation of the present organization and operation of the various units of the Center *"in the light of the rapidly changing picture of medical education, research and service."*

The firm was told to look at the role, program and relationships of the medical school, University hospitals, the school of nursing, the student health service, the State Laboratory of Hygiene and associate institutes.

FULL APPRAISAL

It was also asked to issue a statement upon completion of the survey listing recommended development of roles and programs of these units in the light of objectives of the university and needs of the state; to appraise the organization and operation of the top-level and executive management of the hospitals, the fiscal activities, rates and methods of control in the hospitals, and the professional staff organization of the hospitals.

The firm will make recommendations as to proper space utilization and required construction, and make cost estimates, and develop a schedule of departmental needs to meet present and future programs.

ON THE S.M.S. CALENDAR . . .

June 5—Claims Committee, S.M.S.
5—Convention, Wisconsin Public Health Council, Madison.
5—Meeting, Wisconsin Association for Public Health, Madison
6–8—Governor's Conference on Problems of an Aging Population, Madison.
9—Commission on Prepaid Plans, Chicago.
10–15—A.M.A., Chicago
16–17—Convention, Wisconsin State Medical Assistants' Society, Milwaukee
July 3—Claims Committee, S.M.S.
12—Joint Meeting, Committee on Public Policy and State Board of Medical Examiners, Milwaukee.
27–29—Executive Committee and Council, Land O'Lakes.

Dr. Filek Gets National Post

Mobile, Ala.—Dr. Allan Filek, of Madison, Wis., was named president-elect of the Association of State and Territorial Directors of Local Health Services in April.

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221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

HALO . . .

Another in a series of apt cartoons from a publication entitled IS YOUR HALO ON STRAIGHT is shown below. The HALO series was published for the Ethics and Professional Conduct Council of the Alumni Association of the School of Medicine of the College of Medical Evangelists by San Lucas Press, Los Angeles. It has been described as a "sharp public relations idea, with rapier-like thrusts at physicians who know the shoe fits." HALO shows little feor of treading on toes.

The Pipeline

Leaks lay news ot every pore and seems unaware of the odor.

Asks nothing for quotes on coses he treats except assurance his name is spelled right.

If called to account, claims he's co-operoting with press. Pouts that county society's news standords abort free speech.

Won't understand difference between medical news and personal puffs.

Clamp large paw over his mouth. If he bites, kick him off the team.

Legislative Group to Review Optometry Board Rules and Procedures

Madison—The State Board of Examiners in Optometry will be the first state agency to get a perusal by the Legislative Committee for Review of Administrative Rules.

The Board will appear before the committee sometime in May to explain the how, why and when of its regulations and policies.

The decision to study the agency's procedures was taken after a Madison attorney, Gilbert McDonald, representing optometry firms, complained that the Board had exceeded its authority in filing of rules.

ADV. SIGNS BANNED

Specifically, McDonald contended, the Board had adopted rules containing language similar to bills which failed to pass the 1955 legislature. One of these bans the use of large advertising signs.

McDonald said the Board lacks authority to adopt any rules other than those governing examinations and procedures.

Assemblyman Pellant (D–Milwaukee) called the situation a *"good example of a department creating laws they are not authorized to do."*

He suggested study of a law restricting any agency from enacting in rule form anything that has been defeated in the legislature.

50-Year Club Members Honored at Milwaukee

Milwaukee—The State Medical Society brought recognition May 3 to 13 new members of the *"50 Year Club,"* each of whom has completed a half century of medical practice.

Honored at the Annual Meeting were two past-presidents, **Drs. R. G. Arveson**, Frederic and Charles **Fidler**, Milwaukee; and **Frederick Bauer**, Shawano; **Frank O. Brunckhorst**, Neenah; **Virgil D. Crone**, Beloit; **A. A. Hoyer**, Beaver Dam; **J. F. McNary**, Milwaukee; **Will G. Merrill**, Ashland; **Daniel F. Nauth**, Kiel; **Rolland G. Raymond**, Brownsville;

Joseph F. Rose, Lena; **Frederick W. Seegers**, Milwaukee and **Paul C. Wagner** of Milwaukee.

Medical Assistants to Meet June 16–17

Milwaukee—The Wisconsin State Medical Assistants' Society, organized in 1955, will hold its second annual meeting here June 16–17.

Guest speakers will include **Mrs. Stewart Honeck**, Madison, widely-known authority on style and poise, and **Leo Brown**, Chicago, A.M.A. public relations director.

Membership is open to employes of State Medical Society members, and to persons employed in hospitals and medical laboratories. Physicians are being urged to send their medical assistants to the meeting in Milwaukee.

Hoxsey Cancer "Cure" Declared "Worthless"

Washington — **Beware of the Hoxsey Cancer treatment!**

That was the warning issued by the U.S. Department of Health, Education and Welfare Food and Drug Administration in April.

The U.S. Court of Appeals for the Fifth Circuit, on the basis of evidence presented by the Administration, found the so-called Hoxsey treatment for internal cancer to be *worthless.* Sufferers from the disease, their families, physicians and others were advised of the action and warned to be alert to the problem.

George P. Larrick, U.S. Commissioner of Food and Drugs, declared:

"The Hoxsey treatment involves drugs involving imminent danger to health or gross deception to the consumer. Its sale represents a gross deception to the consumer. It is imminently dangerous to rely upon it in neglect of competent and rational treatment.

DO NOT BE MISLED

"Those afflicted with cancer are warned not to be misled by the false promise that the Hoxsey treatment will cure or alleviate their condition. Cancer can be cured only through surgery or radiation. Death from cancer is inevitable when patients fail to obtain proper medical treatment because of the lure of a painless cure 'without the use of surgery, x-ray or radium,' as claimed by Hoxsey."

Harry M. Hoxsey maintains clinics in **Portage, Pa.,** and **Dallas, Tex.** His charges were reported at $400 plus $60 in additional fees. This covers, Larrick said, a *"superficial, inadequate examination and a series of pills of various colors."*

Hoxsey was enjoined by the U.S. District Court of Dallas in 1953 from shipping his worthless cancer medicines in interstate commerce with labeling suggesting, representing or implying that the products are effective in treatment of any kind of internal cancer.

NOT ONE CURE

Larrick said the government intends to prosecute violations of the injunction. The action, in 1953 and 1956, followed a thorough and long-continuing investigation of Hoxsey's treatment. The Administration said it has **not found a single verified cure** effected by the Hoxsey method.

Senator Wiley

Sen. Wiley Asks Changes In Internal Revenue Code

Chicago—Congress *"very definitely"* should take action to help self-employed persons save up for their later years, U. S. Sen. Alexander J. Wiley, Republican from Wisconsin, said in a recent radio interview.

Speaking over WGN in support of the Jenkins-Keogh bills relating to changes in the Federal Internal Revenue Code, the senator declared:

DEFER TAX PAYMENTS

"One proposal which to me has very definite attractive features is one which would permit various self-employed people temporarily to postpone paying taxes on a limited amount of money during their most productive years, so that they can build up some savings for their later years.

"In other words, let them build up their nest egg for their retirement years. Right now, the House of Representatives has before it the Jenkins-Keogh bills. This sound legislation would affect up to 10 million self-employed Americans—doctors, lawyers, architects, engineers, accountants, shopkeepers, farmers and workers who are not now covered under pension plans of employers."

INCOME VARIES

Some persons, Wiley said, have only a few years of high income, and "then for the rest of their life, may have only a very modest income. In the one or two or three years of peak income, Uncle Sam will confiscate almost their entire earnings. In later years, there is very little to show.

"The new concept would permit folks to average their income over a period of time so they would be taxed at relatively reasonable rates in any one year."

The Wisconsin senator's stand won high praise from **Frank G. Dickinson**, AMA representative of the Coordinating Committee on Pensions for the Self-Employed and the Pensionless Employed. Dickinson said the Association had been trying for years to effect the changes urged by Wiley.

Disability Payment Measure Assailed By Generalists

Washington — The American Academy of General Practice has joined the chorus of opposition to disability payments under H.R. 7225.

Delegates to the Academy's ninth scientific assembly recorded their disapproval of the House-passed amendments to the social security law (H.R. 7225) that would give cash payments to the disabled at age 50.

REVIEW SOUGHT

Dr. Malcolm E. Phelps, of El Reno, Okla., named president-elect, called for a *"searching review"* of social security. He warned that if the present trend for more benefits and increased contributions continues, many citizens *"soon will be paying more to the social security tax collector than to the income tax collector."*

In a letter to members of the House and Senate, delegates urged removal of the disability section of the measure. They made these points:

1. H.R. 7225 falsely assumes that disability determination is an exact science when actually such determination hinges on nature and extent of causative factors, on a doctor's diagnostic skill, and on the willingness of the patient to be rehabilitated.

COST PROHIBITIVE

2. Testimony developed at the recent Senate hearings indicates the annual cost of the disability program if extended to workers of all ages could exceed two billion dollars annually.

Proper Medical Testing Insured at Oshkosh

Oshkosh — The Oshkosh Board of Education recently acted to insure proper medical attention for pupils participating in athletics and physical education classes.

The Board voted to clarify a rule relating to physical examination of boys and girls. In the future all examinations must be made *"by a doctor licensed in Wisconsin to practice medicine and surgery."*

The new wording, a Board spokesman said, eliminates the possibility of cultists, limited practitioners and others without an M.D. degree giving the examinations.

A number of Oshkosh area chiropractors protested the rule change.

Forceful Booklets on Quackery Available

Madison—Are you armed with sufficient ammunition to help educate your patients to the dangers involved in quackery, in spurious claims for curing diseases of all types?

Are you alarmed by the spread of quackery? *You should be,* Doctor.

Two new pamphlets are available to provide Wisconsin physicians with the guns to fight gullible claims to cure cancer and other diseases.

One is QUACKS ARE FOR THE DUCKS, a publication of the Wisconsin Division of the American Cancer Society. Available *without* cost, it presents a brief but *forceful* message about the threat of cancer quackery and is a positive approach for your patients.

The second booklet is FACTS YOU SHOULD KNOW ABOUT HEALTH CURES. It supplies detailed, enlightening information about the efforts of cultists and quacks to fool the American public. It was published at the direction of the *Association of Better Business Bureaus,* New York, and is available at 10 cents a copy.

Order either or both of these pamphlets through the State Medical Society, Box 1109, Madison.

The physician, more than anyone else, should stand up and be counted in favor of sound health care.

MICHIGAN HUBBUB . . .

(Continued from page 570)

"The public's demand in the last decade for better medical and hospital care has been great. Therefore, on top of inflation must be added the cost of this improved care. An increase in Blue Cross rates might, then, be considered automatic.

"The question is: *Do the allegedly excessive rates reflect only inflation and improved care?*

ABUSES CHARGED

"Ample proof to the contrary appears in surveys of hospital cases covered by hospitalization insurance. The studies indicate clearly that alarming abuses have cropped up. These take the form of unnecessary hospitalization, prolonged stays for convenience or comfort and excessive use of drugs and laboratory facilities.

"The problem remains the same. **Whom do we hiss and boo?**

"*Is it hospitals for operating inefficiently?* Is it physicians who find it convenient to group patients in hospitals for quick and lucrative rounds of call that require only an hour or so each morning? Is it patients who unnecessarily demand and get from their doctors a hospital bed and costly care? Is it Blue Cross for permitting such known abuses to continue?

"Frankly, we suspect the answer to all such questions may be 'Yes.'

"At least one offered solution appears to be precipitous and short-sighted. A bill introduced in the Michigan Legislature suggests a deductible plan similar to auto insurance. The proposal to make subscribers pay for the first day of hospitalization and 15 per cent after seven days no doubt would cut rates. It also would greatly reduce the value of the service. It would not, we believe, strike hard enough at the abuses.

OPTIONAL PLANS ASKED

"It would, however, seem logical to offer optional plans. Blue Cross has such a plan, in which the patient pays the cost of the first two days and $2 a day for the remainder of the hospital stay. The saving of but 16 per cent in premiums does not seem adequate, considering that the average stay is seven days. Blue Cross also is readying a 'catastrophe' policy, but if the saving is no greater than offered under the year-old deductible plan it too probably will not be widely popular.

HAVE MD'S FAILED?

"One additional thought stands out prominently. Physicians, through their dealings with patients and because they control both the hospitals and the Blue Cross organization, have failed in our estimation, to take an active public stand on the abuses under the voluntary hospitalization insurance plans.

"Because they are so closely involved in the abuses and because voluntary plans were their answers in a period when socialized medicine appeared around the corner, they should be available to counsel the public. The public wholeheartedly accepted the voluntary plans and should have the wise advice of doctors."

House Gets New Aged Hospitalization Plan

Washington — For the fourth time, the House of Representatives has a bill calling for hospitalization of the aged.

This time it was introduced by **Rep. Dingell (D–Mich.).** It was first introduced by the former Federal Security Administration head, Oscar Ewing, and then twice by Rep. Dingell's late father.

Provisions of the new proposal in brief:

Maximum of 60 days free hospitalization a year, if ordered by a physician, for any social security beneficiary or dependents; *excluded* would be surgery or medical care (except that generally furnished by hospitals), tuberculosis, mental conditions or domiciliary or nursing type care; *included* would be nursing and lab, ambulance, drug and operation room costs;

Secretary of HEW Folsom would make regulations, with advice from Federal Hospital Council; states, operating as agents of the U.S., would make arrangements with hospitals;

Payments would come out of Old Age Survivors' Insurance trust fund without additional tax.

Mass Education Programs Pay Off

Princeton, N. J.—Mass education programs of voluntary health groups have been very helpful in getting people to the doctor in earlier stages of illness.

So indicated more than 500 physicians who participated in a survey conducted recently by the National Opinion Research Center, under a grant from the Health Information Foundation.

EARLIER TREATMENT

The doctors said they were convinced that more people come to their offices sooner than they did in 1946, especially in the case of cancer.

Almost all of the physicians said the patient should see a doctor right away about symptoms, such as a sore that doesn't heal, an unusual bleeding or discharge, or a persistent cough, which might signify cancer.

The average M.D. surveyed believes that all adults should get a general physical checkup every year, and thinks it is extremely important for the public to be informed about health and medical matters.

Other findings included:

TESTS APPROVED

Monthly breast self-examination for cancer was approved by 79 per cent of the physicians, while semi-annual pelvic examinations for all women over 35 was approved by 71 per cent. Semi-annual chest x-ray tests for all men over 45 were approved by 42 per cent.

Ninety-eight per cent believe the mass education programs on such conditions as heart disease, tuberculosis and cancer have served a constructive purpose. In response to the question, *"Do you believe these programs have done any harm?"* 56 per cent said, *"No, none at all."* Forty-four per cent said *"Yes, in some way in arousing fear."*

OPPOSE "SCARE" APPEALS

Less than seven per cent suggested less emphasis on fear of disease in information programs and fund-raising appeals. Seventeen per cent urged more public education.

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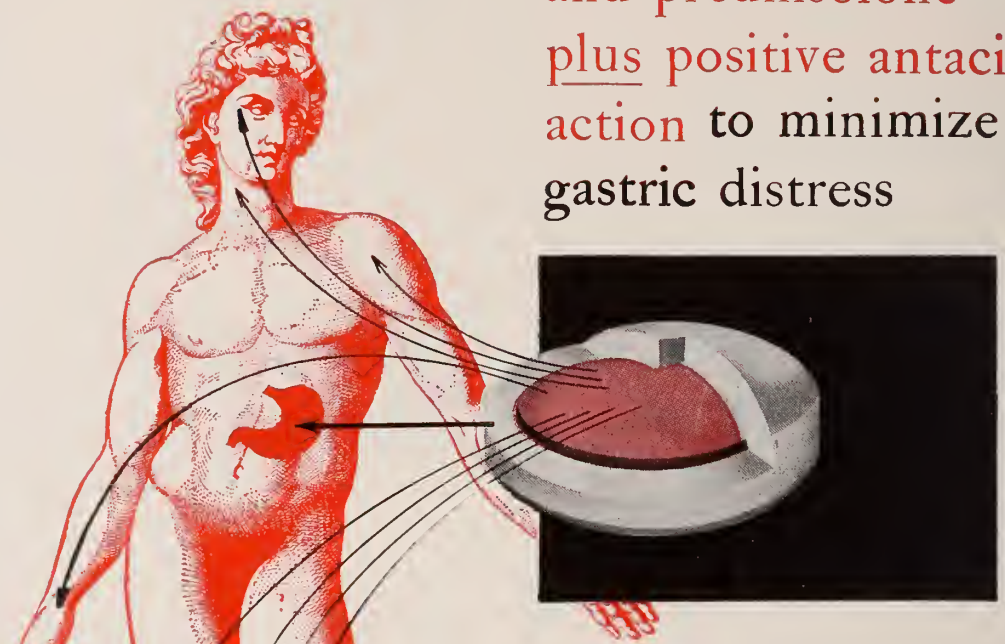

Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

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OBITUARIES

Dr. Valentine Gudex, retired Milwaukee physician, died on February 17 at the age of 91 years.

Doctor Gudex was born in Barton, Wisconsin. He attended Valparaiso University, from which he was graduated in 1884. In 1886, he was graduated from the Chicago College of Dental Surgery and in 1895 from the Milwaukee Medical College.

For one year, he was acting assistant surgeon of the Federal public health service for the Wisconsin area. In 1919 he began his duties as public health officer, and continued in this post until his death.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving Doctor Gudex are his wife, Minnie; two sons, Arthur, Plymouth, and Junius, Owen; and three daughters, Mrs. Cleo Boyer, Mrs. Mildred Hoppe, and Mrs. Audrey Zettinig, all of Milwaukee.

Dr. J. E. Gonce, professor of pediatrics at the University of Wisconsin and a member of its faculty since 1919, died on March 25 at the age of 62 years.

Doctor Gonce was born in 1893 in Elkton, Maryland. He was graduated from the University of Pennsylvania School of Medicine in 1918. He joined the University of Wisconsin staff in 1919, and had been a professor of pediatrics since 1932.

He was a frequent contributor to medical journals, with articles on the general field of pediatrics, and also a contributor to Grulee and Eley's textbook on pediatrics.

Doctor Gonce was a fellow of the American College of Physicians; a member and past president of the Dane County Medical Society; and a member of the State Medical Society of Wisconsin, the American Medical Association, and the American Academy of Pediatrics.

Surviving are his wife, the former Louise Allyn; two sons, John Eugene, III, Houston, Texas, and Richard Allyn, Fort Bliss, Texas; and one brother, Robert L. of Elkton, Maryland.

Dr. Frederick Peehn, 81-year-old Sturtevant physician, died March 24 at a Racine hospital after suffering a heart attack.

Doctor Peehn was born in 1874 at Ives Grove, Wisconsin. He attended Whitewater State College prior to getting his medical education at Marquette University. In 1900 he began his practice at Sturtevant, where he remained for 56 years.

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He was a member of the Racine County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving are his widow; one daughter, Mrs. Doris Davidson, Racine; and two grandchildren, Donna and Dean Davidson.

Dr. John P. Harkins, 64-year-old Portage physician and surgeon, passed away on March 9 at his home.

Doctor Harkins graduated from Loyola University, and received his medical degree at the Chicago Eye, Ear, Nose and Throat School in 1915. He was on the staff of the Sullivan Clinic in Madison, Wisconsin, before locating in Portage in 1933. He also maintained an office in Baraboo which he visited regularly.

He was a member and past president of the Columbia–Marquette–Adams County Medical Society, a member of the State Medical Society of Wisconsin and the American Medical Association. He belonged to the American Legion and the Rotary Club of Portage.

Doctor Harkins is survived by his wife, Lillian; one son, Dr. Edward J.; two grandsons; one brother; and four sisters.

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The medical profession's concern for adequate protection for the nation's patients has continued to grow with the problem, and it is now more effectively expressed in Blue Shield than ever before. But it should be remembered that the public's endorsement of Blue Shield and Blue Cross to date does not necessarily indicate complete acceptance of all their philosophies or policies, but might be largely the result of expediency in that these plans have currently satisfied some of the public's longing for adequate and reasonable health expense protection. As the plans reach toward maximum size in a highly competitive field, it is natural that the public will express greater interest in the total concepts of Blue Shield and Blue Cross since they have been taught that they are *part* of the plans.

The *Buffalo Evening News* has recently published some pertinent editorial comments on this matter which should help physicians in their thinking:

"Blue Shield is the 'doctors' own medical prepayment plan, to be sure, but it operates under enabling laws in the public interest. If the doctors, cooperatively and voluntarily, did not operate their medical insurance plans with due regard for that public interest, the public would soon turn elsewhere. If it felt it could not look to Blue Shield for effective coverage, or for the kind of protection it expected to get from the premiums it was paying, the result would be the biggest push anyone could give toward governmentally socialized medicine.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Story of You. By Edgar A. Cockefair, biologist, and Ada Milam Cockefair, former teacher of physiology in West High School, Madison, Wisconsin. Madison, Milam Publications, 1955. Price $2.00 (20% discount to physicians).

This little book of 34 pages is intended to provide sex instruction to nursery school children and those just beginning to read. In the language of nursery tales at their best, it briefly tells about love and marriage, conception, pregnancy, birth, infant feeding, and growth and development of the infant and growing child. A large part of each page of the book is taken up by attractive, pertinent illustrations drawn by art-gifted high school students. It is an authoritative answer to the fleeting curiosity of children of this age group.—J.E.G.

Bickham–Callander Surgery of the Alimentary Tract. By Richard T. Schackelford, M. D., Assistant Professor of Surgery, Johns Hopkins University School of Medicine. Assisted by Hammond J. Dugan, M. D., Assistant in Surgery, Johns Hopkins University School of Medicine. Philadelphia and London, W. B. Saunders Company, 1955.

The three-volume revision of *Bickham–Callander Surgery of the Alimentary Tract* by Richard T. Shackelford is the most comprehensive work of its kind and goes further than the older editions in that Doctor Shackelford offers an evaluation of every procedure described, basing his comments on his own experience and the reports from the literature. For those procedures which do not seem to be the best, he points out in what respects they are lacking. He also describes the diseases or lesions for which the operation is used and the stage at which it should be undertaken, and has elucidated the indications and contraindications to alternate procedures. Volume one deals with the esophagus, stomach and duodenum, liver, gallbladder, and extrahepatic biliary ducts. Volume two deals with the pancreas, spleen, small intestine, peritoneum, omentum, mesentery, and colon. Volume three deals with the anorectal tract, excisions of the rectum, hernia of the gastrointestinal tract, and incisions. In all three volumes pre- and postoperative care are described in detail.

As is noted in the preface, many of the illustrations have been borrowed from published books such as Richard Sweet's *Thoracic Surgery*, Robert Gross' *Surgery in Infancy and Childhood*, and Bacon's *Anus, Rectum, and Sigmoid Colon*. Statistical figures are quoted from these works and from reports in the literature.

Careful survey of the three volumes leads me to the conclusion that this is an excellent work which is carefully edited and painstakingly illustrated, and that it includes a discussion of almost every type of operative procedure in current use on the gastrointestinal tract today.

This book is highly recommended to all those doing surgery or interested in doing surgery, particularly to the occasional surgeon or to the young surgeon where the indications and applications of the respective procedures will be invaluable. It is a must for all medical libraries.—K.E.L.

Emotions and Bodily Changes. By Flanders Dunbar, M. D., Med. Sc. D., Ph.D., Fourth Edition. New York, Columbia University Press, 1954. Price $15.00.

As a survey of literature on psychosomatic interrelationships from 1910 through 1953, this fourth edition of Doctor Dunbar's book now contains 5,142 references. The original format has been retained; there have been few if any deletions, some revisions, and many additions. Psychoanalytical concepts continue to dominate the material. The scope of the references covers the broad spectrum of fact and fancy that has characterized the development of psychosomatic medicine. Since there is no attempt to select articles on the basis of their validity or factual value, the reader is confronted by a large mass of material which he might enjoy if he is historically inclined, but which he must carefully scrutinize if he is seeking useful knowledge.

Because of its extensive bibliography, this volume has a place as a source of reference material. Un-

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fortunately, it will appeal to a limited audience since it is too long and comprehensive for the student and nonpsychiatric practitioner and insufficiently critical and factual for the scientific investigator.—M.J.M.

Public Relations in Medical Practice. By James E. Bryan, Administrator, Medical-Surgical Plan of New Jersey; Formerly Executive Secretary, Westchester County Medical Society; Executive Secretary, New York County Medical Society; Executive Officer, The Medical Society of New Jersey; and Chairman, Medical Society Executives Conference. Baltimore, The Williams & Wilkins Company, 1954.

This volume is a very excellently written work on a subject which, in the opinion of this reviewer, has received too little attention in the past. Mr. James E. Bryan very effectively turns the cold, white light of public opinion upon the various relationships that the doctor meets in the course of his everyday practice. The very problems that have received the most attention in the public press and on radio and television in the past five years are highlighted in this book. Sensible and workable suggestions are made for the improvement of the public relations of the medical profession with regard to these problems.

The division into chapters, each of which spotlights a certain aspect of the doctor's public relations, is effective. It is my opinion that at times the chapters drag somewhat and there is an attempt to include too much material under each heading. For the most part, however, the book is extremely readable and the material contained therein well organized. I especially liked Mr. Bryan's use of quotations from various sources to support his contentions, which I believe gives the book authority and authenticity.

It is my opinion that *Public Relations in Medical Practice* would be excellent extracurricular reading for all physicians and for those who frequently come in contact with physicians.—R.C.P.

Prolonged and Perplexing Fevers. By Chester S. Keefer, M. D., Physician-in-Chief and Director, Evans Memorial, Massachusetts Memorial Hospitals; Wade Professor of Medicine, Boston University School of Medicine, and Samuel E. Leard, M. D., Assistant Visiting Physician and Assistant Member, Evans Memorial, Massachusetts Memorial Hospitals; Instructor in Medicine, Boston University School of Medicine. Boston and Toronto, Little, Brown and Company, 1955. Price $5.50.

Reviewing this book was a disappointing experience. It seems likely that the senior author had only sufficient time to give the volume a superficial blessing. This becomes apparent from the lack of technical skill in writing, the paucity of first-hand clinical material, and the fact that antibiotics were not included in the short list of drugs most apt to cause fever.

The first chapter is concerned with variations in normal body temperature and the mechanism involved. This subject is more adequately covered in most standard physiology texts. The authors write

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about the first crude methods of obtaining body temperature, but fail to mention the modern continuous-recording devices used to study fluctuations of temperature more precisely.

The chapter on diagnostic procedures is poorly organized and repetitious. It superficially disposes of this important aspect of clinical medicine and is noteworthy for several important omissions. Chronic lung abscess and empyema are not mentioned as causes of clubbing of the fingers. Albuminuria is not included as a finding in febrile states. The importance of repeated blood cultures is not emphasized. Several useful complement fixation tests are omitted. Under the heading of x-ray examination, no mention is made of pericarditis. Adequate filling of the kidney pelvis is not stressed, and no consideration is given to retrograde pyelography. The gallbladder, which is a notorious offender in causing obscure fever, is overlooked.

The remainder of this book is concerned with a variety of disease states in which fever is an important finding. Unfortunately, many of the case histories cited are extracted from the literature and are neither convincing nor perplexing. The authors might have avoided severe criticism by dating their cases, since by present-day standards many were grossly mismanaged. This is particularly true of almost every case presented in the chapter on tuberculosis. It should be pointed out that a therapeutic trial of a specific drug such as isoniazide is frequently helpful in directing one's attention to the proper diagnosis. The student or physician will find most of the diseases described in a haphazard manner with important febrile diseases such as malaria receiving only a few lines of comment while other rare diseases are given even an historical review. One is startled to learn that histoplasmosis resembles kala-azar.

This volume is neither a fundamental nor monumental work. In an effort to be charitable the reviewer culled the book for a new idea or even a well-turned phrase. His efforts were not rewarding. —J.K.C.

Clinical Diagnosis. By Elmer G. Wakefield, B.S.A., B.Sc., M.D., F.A.C.P., Consulting Physician, Section of Medicine, Mayo Clinic, and Associate Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. New York, Appleton-Century-Crofts, Inc., 1955. Price $22.50.

The author has attempted to combine several books into one: physical diagnosis, symptom diagnosis, and general medicine-surgery. The result is a useful reference book for office practice. The illustrations are excellent and should be most helpful.—E.C.A.

Current Therapy 1955. Edited by Howard F. Conn, M. D. Philadelphia and London, W. B. Saunders Company, 1955.

Like the preceding volumes of *Current Therapy*, this textbook makes an excellent handbook for the physician in the general practice of medicine. A wide variety of diseases is covered, and the emphasis is very definitely on prevention and treatment. In most cases the method of treatment preferred by several authorities is given for each disease condition. The volume is well indexed and easy to use, and the information therein is very specific and immediately useful.

In the opinion of this reviewer Doctor Conn has done a great service to medicine in editing this volume, and I think that it should be a reference on every physician's desk. In each case the descriptions have been stripped of verbosity and gobbledegook so that the presentations could in no way be misconstrued. No attempt is made to describe operative surgery where this must be performed, but the preoperative and postoperative treatment is very well defined in all cases.—R.C.P.

Galen of Pergamon. By George Sarton. Lawrence, Kansas, University of Kansas Press, 1954. Price $2.50.

This little book summarizes conveniently what is known concerning the life and work of the man who, next to Hippocrates, was the most famous physician of antiquity and ruled medicine supreme for more than 1,300 years after his death.—E.H.A.

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INDEX TO ADVERTISERS

	Page
American Meat Institute	516
Ayerst Laboratories	557
Baker Laboratories	579
Barr X-Ray Company	578
Bayer Company	507
Benson Optical Company	566
Brown and Williamson Tobacco Corp.	587
Burroughs Wellcome & Co., Inc.	508
Ciba Pharmaceutical Products	582
Cook County Graduate School of Medicine	500
Davies, Rose & Co., Ltd.	565
Doerflinger Artificial Limb Co.	565
Endocrine Laboratories	575
Foot-so-Port Shoe Company	575
Gyne–Cytology Laboratory	500
Hotel Schroeder	557
House of Bidwell	584
Hurley X-Ray Company	556
Keeley Institute	582
Kennedy Mansfield	583
Knox Gelatine	503
Lakeside Laboratories	556, 564, 578
Lederle Laboratories	540, 541
Lilly, Eli and Company	520
Mallard, Incorporated	575
Mallatt Pharmacy	583
Mather Pharmacy	583
Mead Johnson and Company	510
Medical Protective Company	578
Milwaukee Sanitarium Foundation, Inc.	592
New York Polyclinic	582
Orthopedic Appliance Company	557
Parke, Davis and Company	498, 499, 558, 559
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	513, 589
Physicians Casualty Association	588
Professional Business Service	571
Quincy X-Ray and Radium Laboratories	566
Rennebohm's	583
Rogers Memorial Sanitarium	592
S. and L. Signal Company, Inc.	500
Sacred Heart Sanitarium	563
St. Croixdale Sanitarium	501
Schering Corporation	509, 514, facing 514, 519
Schmid, Julius, Inc.	515
Searle, G. D. and Company	555
Smith, Kline & French Laboratories	518
Sharp and Dohme	504, 505, 517, 562, 576
Shorewood Hospital Sanitarium	561
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp.	502
Time Insurance Company	569
Training School at Vineland, New Jersey	578
Tutag, S. J., and Company	560
Upjohn Company	501, 535
Wallace Laboratories	511
Winthrop Laboratories	512
Wisconsin Neurological Foundation	577
Wyeth	506, 561

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1. Spies, T. D., et al.: GP 12:73, No. 1. 1955. 2. Boland, E. W.: J.A.M.A. 160:613, 1956. 3. Gillhespy, R. O. Lancet 2:1393, 1955.

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. E. Kreher Ashland	J. M. Jauquet 220 7th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe Rice Lake	F. H. Goetsch Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	Louis Milson 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	Kenneth Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	B. J. Haines Cadott	Second Tuesday
Clark	J. W. Koch Colby	T. N. Thompson Neillsville	
Columbia–Marquette–Adams	H. Y. Fredrick Box 253 Westfield	F. W. Gissal 132 Washington Ave. Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	W. S. Cusick Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. S. Gearhart 621 S. Park Madison	T. V. Geppert 113 N. Carroll Madison	Second Tuesday Sept. through June
Dodge	R. I. Bender 147 Front Beaver Dam	M. E. Royce Mayville	Last Thursday*
Douglas	Conrad Giesen 1514 Ogden Superior	J. McGinnis 2231 E. Fifth Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	R. A. Buckley 131 S. Barstow Eau Claire	G. E. Wahl 616 E. Grand Eau Claire	Last Monday
Fond du Lac	Josephine N. Pallin 73 W. 12th Fond du Lac	H. J. McLane 80 Sheboygan St. Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	J. W. Conklin Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept, and Nov.
Green	F. J. Bongiorno Albany	D. E. Mings Monroe Clinic Monroe	
Green Lake–Waushara	A. J. Wiesender Berlin	G. C. Stone 124 N. Wisconsin Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	R. W. Quandt 1108 Main Jefferson	C. E. Quandt 804 Lincoln Ave. Jefferson	Third Thursday*

* Except June, July, and August

** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. T. Garren 6124 Sheridan Rd. Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	A. A. Cook 1707 Main La Crosse	J. L. Jaeck 1836 S. Ave. La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	R. E. Hunter Argyle	Last Tuesday
Langlade	W. P. Curran Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah Merrill	
Manitowoc	R. C. Randolph 819 Hancock Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	E. B. Brick 501½ Third Wausau	J. V. Flannery 404 Third Wausau	
Marinette-Florence	R. J. Rogers Oconto	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
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Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	A. F. Slaney Oconto	F. E. Zantow Oconto	
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Outagamie	A. C. Taylor 103 W. College Appleton	H. T. Gross 103 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
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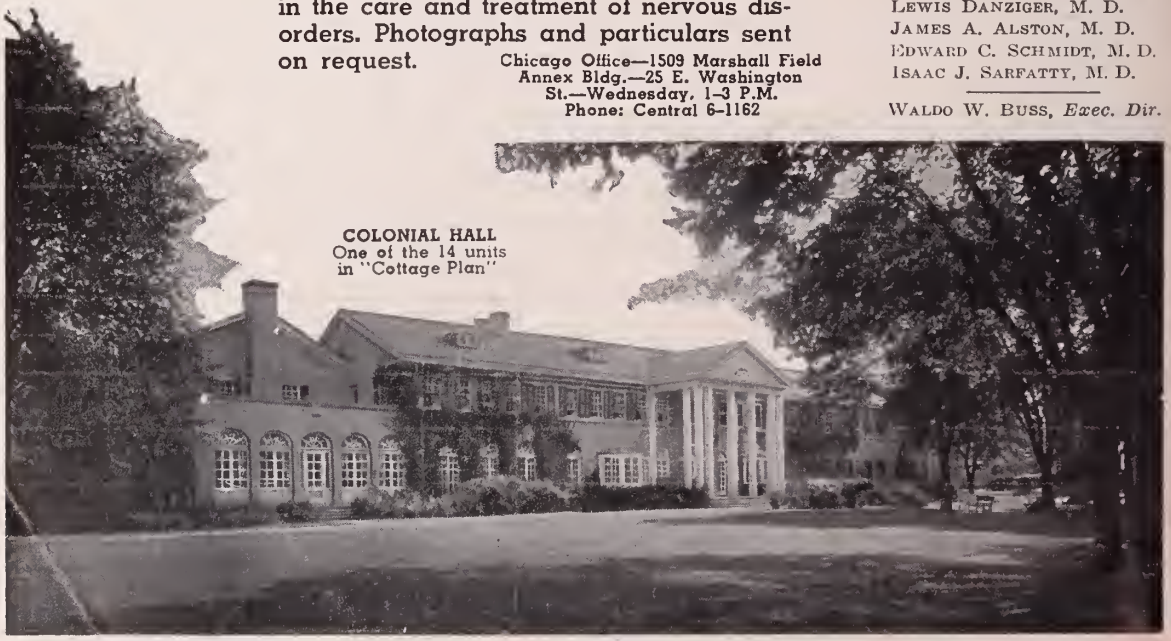

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

Page

The Development of the Clinical Program of the Wisconsin Diagnostic Center, by V. Terrell Davis, M. D. ---- 621

The Management of Ureteral Stone, by C. R. Marquardt, M. D., and J. W. Pick, M. D. ---- 630

Interpolated Vascular Grafts, by H. B. Benjamin, M. D., Marvin Wagner, M. D., Robert Mann, M. D., Walter Zeit, Ph.D., Joseph Kuzma, M. D., and R. K. Ausman ---- 636

Triplets Born to Primigravida, by Homer M. Carter, M. D. ---- 639

Comments on Treatment ---- 641

Clinicopathologic Conference ---- 642

Restaurant Sanitation ---- 647

MISCELLANY

Page

Message to the House of Delegates, by L. O. Simenstad, M. D. ---- 617

Society Proceedings ---- 660

Facts About Wisconsin Physicians Service ---- 668

News Items and Personals ---- 670

Third and Twelfth Districts News ---- 671

Society Records ---- 672

Obituaries ---- 674

The Journal Bookshelf ---- 677

Physicians' Exchange ---- 680

Index to Advertisers ---- 682

EDITORIALS

The Wisconsin Diagnostic Center ---- 659

Hoxsey Hoax ---- 659

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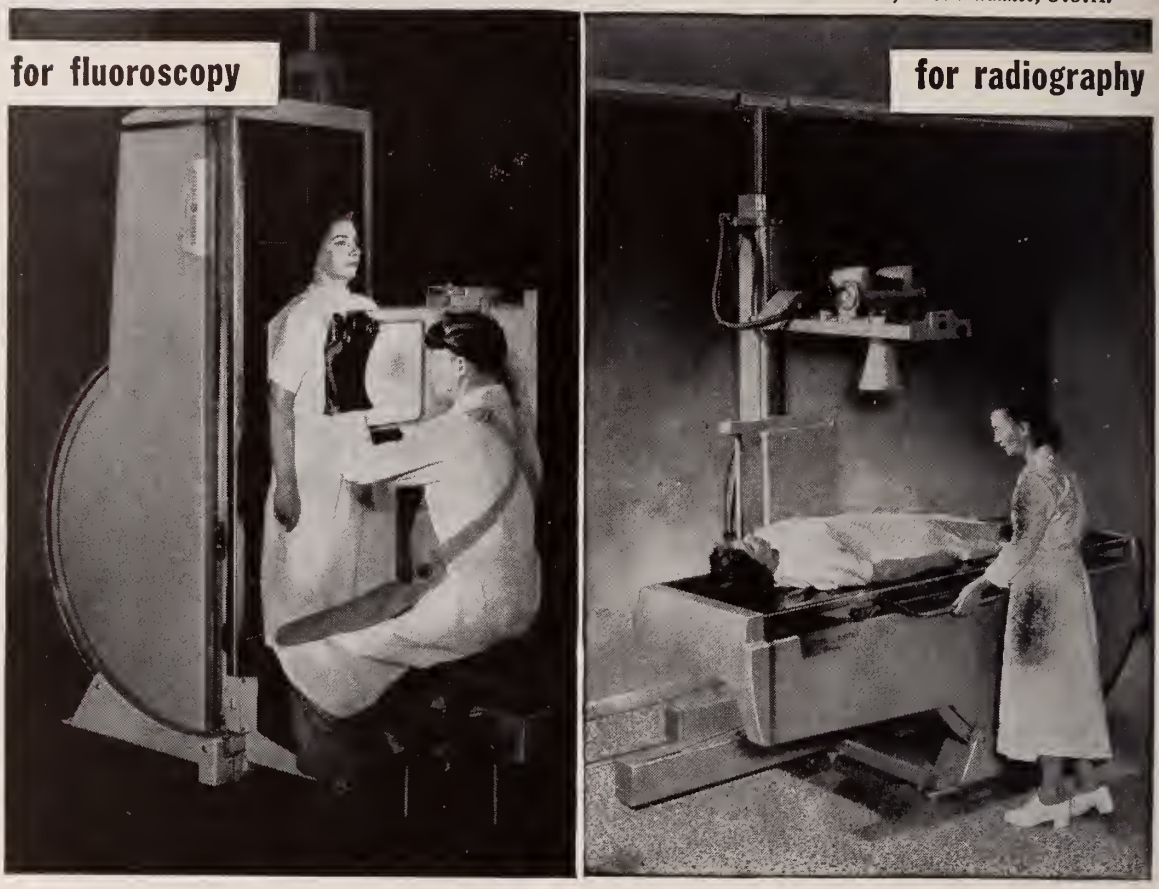

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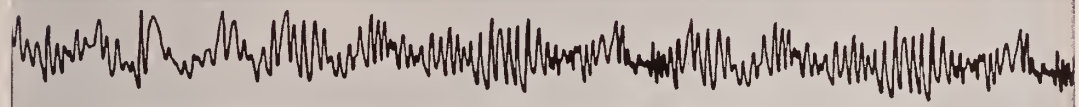

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1. Karp, M., et al.: Am. J. Obst. & Gynec. 69:780 (April) 1955.

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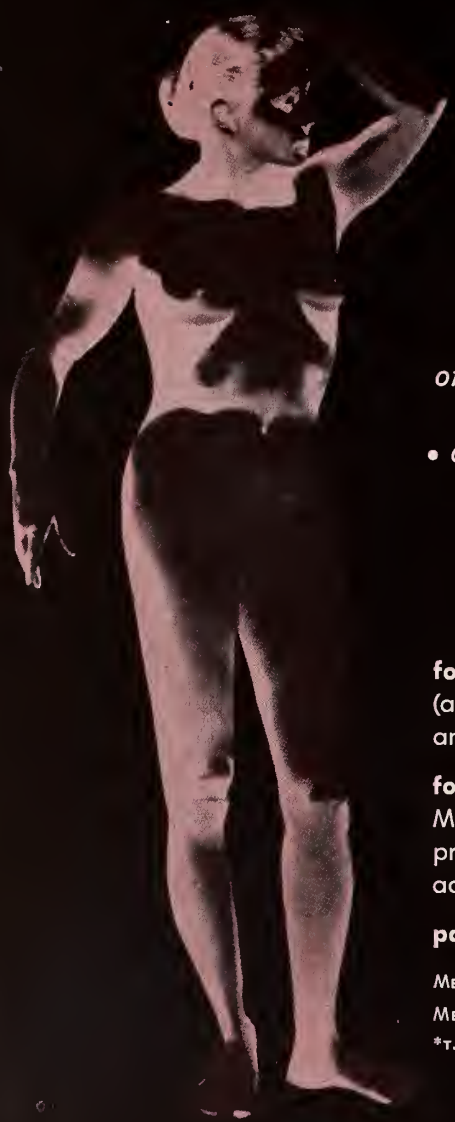

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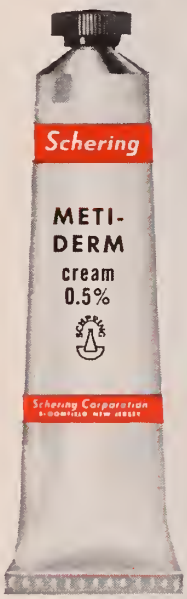

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THE WISCONSIN MEDICAL JOURNAL

Volume 55 JUNE 1956 Number 6

Message to the House of Delegates*

By L. O. SIMENSTAD, M. D.
Osceola

THIS is a moment to which, until a year ago, I had never given a serious thought. In the past 12 months, however, it has been of almost endless concern. I suppose it is inevitable that presidents-elect undergo this experience and in the process be given to moments of reflection. Perhaps that is why I should like to turn for a few moments to a bit of history.

I remember a young man who came to a tiny village of 700 in northwest Wisconsin a little more than 31 years ago. He was recently graduated from medical school. He wanted to be a city specialist some day; but he was recently married, and forced to do a little general practice until he could get on his feet financially and back to a residency. This hamlet looked like a good bet for a few dollars in a few months. It turned out to be quite a few months, and then quite a few years.

His practice grew. His patients were loyal. There was hard work, lots of it. Soon his own loyalty turned away from the fading dream of specialization to the community and its people—his patients. It was not long before he was embroiled in local civic affairs. Soon he was enticed into offices in the local medical society. In the eyes of some of his colleagues and not a few of his patients, he was a medical politician.

I don't suppose I have to tell you who that man was. Here I am—standing before you tonight not a little surprised to be here.

I tell you this, I assure you, in utmost humility. I hope you might understand what it feels like to be a small-town physician about to jump headlong into the hot caldron of medical organizational affairs.

This past year as president-elect has been a revelation to me. I have observed the vast field of activity of the State Medical Society as I had never before taken the opportunity to do. Your "home" at 330 East Lakeside Street in Madison is a house of many rooms, and from each stems activity that touches every physician and every citizen from one corner of the state to the other. At the same time, into that office goes a steady flow of problems, ranging from those of the lone physician in the isolated north woods village to those of the big city doctor and his hundreds of colleagues with the most elaborate health facilities. Not only is the variety and complexity of this activity enough to make one pause, but the time and interest shown by committee members and members of the various commissions, councilors, and officers is to me almost unbelievable.

Yet, despite the reporting of these activities in the Medical Journal and at various meetings, and even the detailed summaries presented in the Delegates' Handbook, it is my observation that many members of the profession fail to understand the value of the Society to themselves and are almost totally unappreciative of the energies involved. It is not that these members are unappreciative by intent. They are unappreciative because they have not been exposed. It is something akin to the patient who all too often lacks an understanding of the endless formal and informal learning processes to which the physician must subject himself to be worthy of his calling.

A moment ago, I mentioned that, until last year, I had never really *taken* the opportu-

*Presented before the House of Delegates, One Hundred Fifteenth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, May 1, 1956.

nity to see all the ramifications of Society affairs. More than likely, I had not *had* the opportunity; or at least I had not felt that the opportunity was mine to take. Though I realize I was mistaken, this feeling must certainly be shared by many members; and it leads me to a specific recommendation.

I believe that a plan of inviting various county society officers to particular meetings of some of these larger Society affairs could be of great value. I suggest, for example, that the Council should plan one or two sessions each year to which such officers would be invited according to a schedule, perhaps half of the county society officers to each session. The same plan could well be applied to our Commission on State Departments and our Commission on Prepaid Plans. Both groups are outstanding in the responsibilities assigned to them; and physicians from the various county societies would be amazed, I am sure, at the amount of consideration and study required in handling problems of personal concern to each of you.

There is no question that the active affairs of the Society arise in part out of the increased momentum of all political life. The doctor's greatest endeavor seems to be to keep current. I know that much is reported in our own publications; but I believe that a periodic newsletter directed to all county society presidents, secretaries, delegates, and alternates would improve liaison and provide these important county society officials with current information necessary to the proper functioning of their offices.

This newsletter might deal frankly and rather fully with such matters as income tax rulings, malpractice insurance, public health projects such as polio vaccine, tips on medical testimony, and membership affairs.

We, in county medical societies, elect these officials to represent us. We have confidence in them. We respect their judgment. And, in accepting their election to office, they accept responsibilities with it. It is their duty to keep abreast of current developments and to keep us, the county society members, informed at various membership meetings. A periodic newsletter from our state headquarters would not be costly and might well effect a savings in that Society news might be more easily dispatched with better results.

When I speak of such efforts directed at our own profession, I am immediately reminded of our interprofessional obligations. Perhaps I should call them "interhuman obligations" because, actually, we should not stop with the education of those who are allied to us in health work but should extend our efforts to the general public. The problem is this, and I have recently witnessed it a number of times. For example:

> The State Medical Society has sponsored eight prematurity institutes for doctors and nurses, yet it is sometimes criticized for failure to recognize the "team approach" to health care.
>
> The State Medical Society has spent thousands of dollars, and individual obstetricians have volunteered thousands of hours of their time in surveys and teaching sessions on maternal mortality. Yet the Society is prodded for not contributing enough to the improvement of patient care.
>
> The State Medical Society has long operated a successful Grievance Committee and even now spends considerable of its monies and energies in the operation of this important phase of Medical Society activity. Yet the Society is often branded as selfishly protecting its own.
>
> The State Medical Society has been a leader in the development of high quality health insurance protection, yet it is often charged with callous indifference to patients' financial problems.

That these misconceptions exist among the general public is regrettable, and yet it is in part understandable for these impressions relate to problems not always easily explained in simple and brief news stories. But I am painfully aware that nurses, pharmacists, hospital administrators, and others who work closely with us often share the same lack of facts and distorted opinion of the medical profession.

Thus, I feel it is an urgent necessity that the interprofessional institutes initiated by my predecessors, Doctors Tenney and Bernhart, be carried on and, if at all possible, expanded to semiannual meetings. I am sure that by meeting together—not by writing letters or exchanging bulletins and journals

but by meeting together in full frankness and sincerity—we can do a great deal to improve our relationships, our understanding of each other, and the welfare of our mutual concern, the patient.

You know me as a physician in a small town on the western edge of our state. Our medical problems by and large are not much different from those of any other area in Wisconsin. Our efforts to maintain a continuing medical education and to provide adequate care for our patients are facilitated by the nearness of the Twin Cities. But we do have a problem in the field of medical-surgical insurance. Being on a state line, our people hear of both Blue Shield of Wisconsin and Blue Shield of Minnesota. We see Blue Shield of Minnesota advertised on television. We physicians must necessarily deal with both plans, and they are not precisely the same. Coverages are different. "A" and "B" programs can be confused. Transfer of protection doesn't always work smoothly. This is true on each of the borders of our state. You physicians in the House of Delegates are being asked to "look into the future" in the report of the Commission on Prepaid Plans. I urge that you do so. There is no turning back from the path created by Blue Shield because Blue Shield is not only a plan but a philosophy. I doubt that state line barriers can be so erected that Blue Shield can always exist tailor-made to a particular area. The benefits and vision of one plan will gradually influence another. I strongly recommend that our knowledge and problems in this field of Blue Shield be made the subject of discussion at least annually by every county medical society and that the Commission on Prepaid Plans undertake a coordinated effort by direct request to the officials of county medical societies. In some areas of the state, it might be feasible to hold district meetings. But no matter how these meetings are held, I urge that they be held—and soon.

Finally, I want to speak briefly on something that has concerned me ever since I first discovered that my interest in medical organization was looked upon as "politics." Unfortunately, the term "politics" has come to have the implication of something self-serving and lacking principle. And I cannot help but be as critical of those among my own colleagues who imply that politics *per se* is "bad" as I am of those among the general public who feel the same way.

For certain specific objectives of interest to the profession, we must band together as doctors; but to win the general regard of the public, we must speak out as individual men. The doctor has qualities which can be of particular use outside his profession in civic affairs. Too seldom do doctors make use of their influence as citizens, despite the fact that they are one of the best educated groups in America and have a greater opportunity than most men to know and understand people and their social, economic, and political problems. This situation is true for the physician whether it relates to medical affairs or civic problems.

You can see that I am genuinely concerned lest our county society officers and those who serve on local or state committees or who participate actively in civic affairs be received by their colleagues and the public with more reproach than respect. Nothing could be more damaging to the medical profession. I ask you in all sincerity to think of this as I ask you four simple questions:

Is it politics when a committee devotes endless hours to devising the means for reducing fetal and neonatal deaths in Wisconsin?

Is it politics when the State Medical Society fights to prevent quacks and cultists from pawning off their oddly conceived and ill-trained practice on an unknowing public?

Is it politics when the Society seeks to preserve the right of the patient to have the physician of his choice and the insurance plan of his desire for the finest kind of health care the world has ever seen?

Is it politics when a physician finds a place on the common council, the school board, the chamber of commerce, or the P.T.A.?

Those who call such effort "politics" are quite correct, but it is "politics" in the sense that it is the most effective way for physicians and the public to conduct their collective business.

If I appear to have belabored the point of interprofessional relations and intraprofessional relations, it is by intention. I am

impressed by what I have learned about the State Medical Society during the past year, and I am certain that the average, hard-working practitioner in Wisconsin would be immeasurably benefited by knowing the Society as I have come to know it. I am likewise certain that our allies in the related health professions and we ourselves could profit from a better mutual understanding. To me, the first obligation of the State Medical Society is to serve its members and to have its members know the Society, its work, its problems, and its concern for each individual member. As officers, councilors, delegates, and committee members of our Society, we already give a great deal of time and effort to specific programs. I urge that each of you go one step further and explain your work and that of the Society to your colleagues in your own local areas. Our Society will thus be stronger and our physicians better able to practice their profession.

CLINICAL MEMORANDUM ON ECONOMIC POISONS

Wisconsin is one of several states in which the use of economic poisons in public health and agriculture is sufficiently widespread to present serious toxic hazards to man. The State Department of Agriculture has warned of serious grasshopper infestation during the coming summer. The canning industry in Wisconsin presents obvious danger spots.

The technical development laboratories of the technology branch of the Communicable Disease Center of the U. S. Public Health Service have conducted laboratory and field studies to determine the toxic hazards in the use of economic poisons. These investigations included special clinical studies. On the basis of these research findings, as well as information available from other sources, clinical memoranda are prepared for each of the more important economic poisons.

They have been prepared primarily for the guidance of physicians in the diagnosis and treatment of persons who may have had extensive or intensive exposure to insecticides. A part of each memorandum is devoted to a description of the chemical nature, formulations, and uses of the compound under consideration. This is intended as a guide to the attending physician in questioning the patient on his exposure to economic poisons or their solvents. The remainder of each memorandum is devoted to medical considerations, including mode of action and diagnosis and treatment.

Among the more important economic poisons and their solvents discussed in the clinical memoranda on economic poisons are the following:

Benzene Hexachloride
Chlordane
DDT
Demeton
Dieldrin
Dilan
Dinitrophenols
Kerosene
Parathion
Sodium Fluoroacetate
Tetraethyl Pyrophosphate
Toxaphene
Warfarin
Xylene

The Committee on Industrial Health of the State Medical Society has been able to receive several hundred copies of these clinical memoranda through the cooperation of the National Agricultural Chemicals Association and the industrial hygiene unit of the State Board of Health. Physicians may obtain one or more copies upon request to the State Medical Society, Box 1109, Madison 1, Wisconsin.

The Committee on Industrial Health urges all physicians, particularly those in the muck farming and canning areas, to obtain a copy of the clinical memoranda and to give it careful consideration in anticipation of encountering the problem of exposure to economic poisons among their patients.

The Development of the Clinical Program of the Wisconsin Diagnostic Center*

By V. TERRELL DAVIS, M. D.**
Trenton, N. J.

Introduction

THE opportunity to see the relatively simple beginnings of the structuring of the problems we have to deal with in psychiatry is a rare experience. We are daily reminded of how nice it would be if we could have worked with this or that patient 5, 10, 15, or 20 years ago when the problems were just beginning. We are acutely aware of the complicating effects of relationships between family, community, and work groups over which we have no control as therapists and the functioning of which we are unable to accurately observe and evaluate. Most of our progress has to come as a result of modifying, altering, adapting, and changing that which is already present.

The staff at the Wisconsin Diagnostic Center has had the unique privilege of observing the development of a new institution and the development of the procedure for a new approach to old problems, and it has been participating in the development of a clinical team to work in an area which has been pioneered on a theoretical basis, but which has not been actually charted heretofore. In the course of the first six months of this operation, there have been certain observable developments and reactions which I feel make a contribution to our factual knowledge of the understanding of human behavior.

The Diagnostic Center was established as a result of an act of the Wisconsin State Legislature passed in 1944 which reads as follows:***

> "46.04 (1) There shall be constructed near the Wisconsin general hospital a hospital type building to be known as the 'Wisconsin Diagnostic Center' which shall be equipped and serviced for the temporary residence and diagnosis of persons committed to the services or institutions under the jurisdiction of the state department of public welfare, except that those patients committed to the Mendota state hospital and the Winnebago state hospital may be transferred to the diagnostic center only upon recommendation of the superintendent of such hospital and approval of the department director. The department director may also authorize the center to receive any minor for precommitment study upon request of the judge of any juvenile court in which a case is pending. The diagnostic center and its services shall be administered by the state department of public welfare and shall be staffed in its diagnostic services by professionally qualified persons appointed from the teaching staff of the medical school of the university by the dean of the medical school of the university.
>
> "(2) The diagnostic center shall be so administered as to furnish a complete physical and mental inventory of an individual committed to the care and custody of the department of public welfare upon referral by the director, thereby assuring placement in the institution best suited to care for the particular case, development of the most effective curative or rehabilitative procedures in such case, and the most effective coordination of all the institutional facilities provided by the state. For the purposes of co-ordination between the department of public welfare and the medical school of the university an administrative committee is created to be composed of the president of the university, the chairman of the state board of public welfare, the dean of the medical school, and the director of public welfare.

The Significance of Diagnosis

Between 1944 and 1954 there was further development of the philosophy of what could and could not be accomplished by a strictly "diagnostic center." As the opening date of the Diagnostic Center in August, 1954, approached, the question was frequently raised in various quarters, "Where are you going to get the facilities to treat these patients once you have completed your diagnosis?"

There are basically two answers to this question. The Center was planned for the

*Read at the meeting of the Milwaukee Neuropsychiatric Association held April 20, 1955, at Mendota State Hospital, Madison.

** Director of Mental Health for State of New Jersey. Former Assistant Director, Division of Mental Hygiene, Wisconsin State Department of Public Welfare.

*** The 1955 Legislature amended the original act subsequent to the reading of this paper. We are printing here the amended act.

purpose of more adequately utilizing the institutional and other facilities within the Department of Public Welfare on the basis of the findings of the Diagnostic Center's study. This implies that, as a result of study and specific recommendations, a wiser choice of the particular facility could be made. However, in addition to this aspect, there was constructive thinking to the effect that a more complete and more accurate understanding of the nature of the individual problem would in itself provide the basis for a growing improvement in the patterns of living of the individual.

We were already familiar with this idea's counterpart in physical medicine—once the x-ray has been taken and the extent or limitation of the damage to the member has been accurately determined, the approach to the ultimate management and recovery is much more rational and the patient and friends are able to reconcile themselves in a constructive manner to the prolonged period of convalescence which may be indicated and to the ultimate acceptance of the residual disability.

I would like to make a comparison from another frame of reference. It is one thing to prescribe bed rest for pulmonary tuberculosis, but it is quite another matter to prescribe this same regime for an early, operable carcinoma of the lung. It is of relatively inconsequential significance what favorite patent remedies are used for a sore throat as long as it is not due to diphtheria, rheumatic fever, a malignant streptococcus, or some cause requiring specific treatment.

It has often been said that a little knowledge is a dangerous thing. It is also quite true that we have to learn to understand that which we have already discovered and are aware of. When van Leeuwenhoek first discovered bacteria, he opened up a whole area of further investigation. Pasteur discovered that bacteria were responsible for disease. The fear of bacteria which developed gradually turned to respect as it was discovered that bacteria perform essential services to man as well as provide a potential danger and menace. We know that similar-appearing bacteria are capable of differing degrees of danger potential and that the same bacteria have differing danger potentials under different circumstances.

The Nature of Psychopathology

We are witnessing a comparable evolution of our knowledge and understanding of the relationship between mental mechanisms and psychopathology. As we have progressed in the development of projective psychological testing techniques, it has been possible to delve more deeply into the fantasy life of an individual, that portion of his life which is usually personal and secret. As we have improved our skills in psychiatric interviewing, we have also been able to find out more of the intimate details of a patient's attitudes, reactions, and feelings.

The popular radio mystery entitled "The Shadow" tends to imply that evil lurks only in the hearts of evil men, but the skilled psychiatrist has learned through experience with his own therapeutic situations and from such adjuncts as projective testing that this so-called evil is as common in the hearts of men as the saprophytic skin bacteria are common to the skin of man. He also knows from experience that it is only when the usual controls of these impulses or organisms are defective that there is a relative degree of danger. Little Jack Horner, sitting in a corner eating his Christmas pie, accomplished as much by "putting in his thumb and pulling out a plum" as psychiatry does when it "discovers" instinctive drives in an individual but neglects to observe, understand, and evaluate the controls which that individual has at his disposal in dealing with these drives. The major function of the study at the Diagnostic Center is to obtain as accurate as possible an appraisal of the individual's potentials for handling his own difficulties, thereby making it possible to recommend the maximum degree of self-expression in the development of his growth program.

I had my first psychiatric training under Doctor Ebaugh at Colorado Psychopathic Hospital in Denver. You are probably aware of the fact that he was a pioneer in pointing up the toxic manifestation of bromide intoxication. The paradox, of course, about the use of bromides is that, under certain circumstances, they are effective as a sedative; but when the blood level reaches toxic levels, there is an increase in nervous tension and restlessness which is aggravated by increasing the dosage of what was once a sedative drug for an individual. A similar paradoxical

response is very often obtained in psychological management of psychological problems. The very controls which may have been prescribed to modify in a favorable manner the behavior of an individual may be the very factor now contributing to disturbing behavior.

The Problem

Our problem was to develop an in-patient program of activities and study which would make it possible to learn more about the patient's inner controls and would also keep us fully informed of the psychological pressures and controls which the patient was being confronted with while in the living situation at the Diagnostic Center. We have observed that if a new situation is not overtly threatening or productive of panic, an individual will enter with minimum disruption of that situation. Even the charmingly uninhibited "Dennis the Menace" slips without fanfare into the midst of the unsuspecting group and manages to keep himself out of difficulty until he has been able to get the lay of the land.

We have yet to have a patient come to the Diagnostic Center who did not, at least initially, make an adjustment which was nonthreatening to the staff. And so far the patients that we have seen at the Diagnostic Center have been the most difficult patients from the Northern and Southern colonies, the School for Boys at Waukesha, the School for Girls at Oregon, the Reformatory at Green Bay, and foster home placements. The most unusual was one youngster who walked in the front entrance on his hands. He was a severely disturbed youngster who was quite talented in this particular feat, and one might have facetiously suggested that he was trying to "put his best hand forward."

Initial Program Unstructured for the First Patient Group

In view of the pioneering nature of this type of an institution, it was decided to take in the first few patients without attempting to structure routine practices and procedures. It was anticipated that, through the cooperative effort of the staff at all professional levels in dealing with the needs of the patient groups as they became manifest, practices and procedures would be developed which would provide an atmosphere in which there would be maximum opportunity for bringing out the positive potentials of the individual patients, as well as provide an opportunity for the individual patients to demonstrate their own capacity to control their instinctual drives within reasonable limits. It was believed, too, that such an initially unstructured program would permit the introduction of more spontaneous and original contributions from staff members at all professional levels. It came as no surprise when our patients gradually began testing limits, like typical school boys testing the thickness of the ice on the edge of the lake with the ultimate goal of seeing if they can get all the way across.

The Need for Setting Limits and Controls

The earliest problem of the staff was one of an inhibition in the expression of restrictive aggressive activity toward the patients. It was as though each aide, nurse, social worker, psychologist, or psychiatrist was reluctant to firmly set a limit, as if this would be the same as firing the first shot in a fight between staff and patients. Thus, the first problem to be worked out in our structuring and in-service training was to clarify in the minds of all the staff members a distinction between constructive, aggressive, friendly setting of limits and aggressive, hostile, retaliatory controls. We expect this to be a continuous process.

It was next observed that the staff, in avoiding setting limits actively on individual patients, was passively permitting unjust and unrealistic limits to be set by one patient on another patient. We found that this lack of a structured program with clearly defined limits which would serve to protect the patients from each other's aggressions ultimately resulted in the patients' turning their aggression toward the staff and becoming more openly aggressive and difficult to manage. At this time it was apparent that we had established ample motivation for an intensive study of the type of structuring which could be based on our initial experiences with the types of patients that we had seen. Two major learning experiences needed to be achieved in the in-service training which was then undertaken:

1. The staff needed to learn to identify with the patient and try to empathically envision the patient's need for support and control from the staff.
2. The staff needed to learn that in this type of work, as in other phases of

life, the significant and important controls and guides have to be spontaneous and come from within for the staff as well as for the patients.

Workshop Technique in Staff Training

With this latter point in mind, the pattern for our training program was planned to permit the maximum participation of all members of the staff. We made use of workshop study techniques in which the staff was divided into small groups that got together under the leadership of a self-appointed chairman and one resource individual. These groups worked, first of all, on the question of what were the problems which the staff had encountered in dealing with their patients and what questions needed to be answered in order to establish a workable, sound, structured program for them. It was anticipated that the details of the in-service training institute, which was held on an eight-hour, five-day-a-week basis, would evolve day by day; and we only attempted to have the program planned definitely one day in advance, although some planning was on a long-range basis.

It was expected that it would be necessary for the groups to work together for a number of sessions before there would be adequate participation by all members of the group and before there would be adequate communication within the group which would lead to actual clarification of the problems and questions to which each of the staff members needed answers. The daily program of the first week consisted of the following activities:

1. A two-hour group work session.
2. A two-hour report session during which the recorders for each of the four groups reported to a general assembly of the staff on the trend of the deliberation of their group for the previous two-hour period. During this session there was also opportunity for comments from other members of the group and the establishment of group reactions in this larger group.
3. One- or two-hour talks by members of the psychiatric staff on general subjects relating to the dynamics of behavior and the basic factors contributing to the personality development of the child.
4. General studies of equipment needs, with discussion of storing of equipment and supplies and reorganization of equipment functions.

In addition, trips were made to the Wisconsin Child Center, the Wisconsin School for Boys, and the Wisconsin School for Girls.

It had been suggested that one way of having the aides develop a closer understanding of the attitudes, feelings, and problems of the patients would be through the medium of role playing. On several occasions, volunteer members of the ward personnel reenacted problem situations which had developed. Although we found that all members of the staff did not feel comfortable and were not able to participate in these exercises before the group, there was a realistic demonstration of the limitations of any attempt to regulate the relationship between the aides, nursing staff, and patients strictly on the basis of rules. Such role playing also revealed the subtle tendency of the staff to dominate or physically force adherence to their orders or instructions.

We observed that, with each problem that was raised in the study groups and each problem demonstrated in the play acting, there was a clamor from the staff for authoritative answers and instructions as to the handling of the problem.

Tension Develops in the Unstructured Group

As we approached the end of our two-week period and there had been no easy solution to the problems which they had been facing more courageously, no authoritative statements from senior staff as to the proper solution to each problem, there was mounting tension in the group which was expressed in thinly veiled and, at times, open hostility toward the administrative staff. As this became more manifest, we were suddenly impressed with the extreme similarity between the rebellious, tense, uncomfortable attitude on the part of the staff group and the tense, anxious, restless attitude and rebellious acting-out behavior toward the ward personnel which we had observed in patients.

Once it had been called to their attention, the staff seemed to be able to see the similarity between the reaction of the patients and that of their own group in an unstructured situation which was not satisfying

their needs for authority figures to set limits and thereby reduce their own anxiety as to whether or not they would express too much aggression and experience the resultant, unpleasurable feelings of guilt.

We had then discovered that, although we had not planned it in this manner, such an in-service project for the staff members had presented a most favorable medium of enabling them to actually experience a situation comparable to that of a patient's situation in coming to the Diagnostic Center. They were then able to more basically appreciate the need for authority figures in the group relationship to serve the function of setting limits.

Once this had been accomplished, it was possible to move rapidly into the area of working on the answers to the problems that had been brought up, and it was relatively easy to point out that each individual pretty well had the same basic attitudes and ideas as to what limits should be set and when they should be set. It was also apparent that this awareness was based on individual situations and, in general, could not be fixed by a specific rule but had to be fixed in some areas by mutual consent and agreement rather than on a basis of what might be considered right or wrong.

Judgment vs. Authoritarian Rule

In motivating a staff, I like to have them understand that I can tolerate events which have transpired as a result of a defect or error in judgment, but that I am inclined to be extremely intolerant of events that transpire in a situation in which there has been a lack of the exercise of judgment and merely an attempt to dismiss any judgmental action and fall back on a rule or a statement of some individual who was not present.

I like to point out that rules are laws laid down by individuals who have given some thought and consideration to the problem; that at the time these rules are laid down, they represent a positive, constructive act of judgment; and that such rules and laws should be followed until it is demonstrated that the judgment on which they were based was erroneous. At such a time, it is necessary for other individuals to express acts of judgment in repealing or removing these laws. In general, this is what has been happening down through the ages, and laws that have remained in the literature and traditions of our civilization are right because they have successfully stood the test of repeated judgmental study. They may be a tribute to the wisdom and understanding of the individual who first pronounced them. They do not derive their validity from the individual who pronounced them but rather from the fact that they have withstood the test of succeeding judgments.

Staff Anxiety and Patient Behavior

There was one period toward the end of three months' subsequent operation of the Center when the situation on the older male patients' floor nearly got out of hand. In tracing the sequence of events, we found that the first signs of anxiety in the staff had developed in relationship to a 20-year-old patient who, though presenting a fairly intact superficial appearance, concealed a rather seriously disturbed and poorly integrated personality structure. He had come to the attention of authorities because of stealing, but his major problem was in the area of sexual identification. He showed serious and disturbing sexual perversions. Part of his exhibitionistic tendency was to take the slightest evidence of friendliness or interest in conversation as a provocation to relate some of the more intimate details of his sexual problem. Several of the male staff personnel unwittingly encouraged his discussion of these areas until their own anxiety and inability to cope with the problems presented necessitated actions which were recognized by the patient as rejection and were reacted to with open hostility. The resulting tense situation and anxiety, as evidenced by the ward staff, was soon sensed by the younger, teen-age group of patients and was reacted to with a rather typical vicious cycle of increasing acting out followed by guilt, resulting in further anxiety and further acting out.

With the completion of our diagnostic work-up and the transfer of the older patient to a suitable institution, the staff anxiety decreased; and this was followed by a re-establishment of a less anxious adjustment of the teen-age boys on the floor.

Communication Between Staff and Patients

We have found that one of our major and continuing staff training problems centers around the elimination of what seems to be a basic need of most individuals who go into the psychiatric field to encourage the patient

to "talk about his problems." I do not know how much of this drive is on the basis of curiosity, how much is a manifestation of a basic need to be useful and needed and an overemphasis on the popular belief that "you will feel better if you get it off your chest," or what other factors may contribute; but there seems to be no doubt that most of our ward personnel have come with such a motivation. On job description sheets, many of our staff members have indicated their feeling of the importance of being that type of person to whom the patient finds it "easy to talk."

It is necessary to emphasize that it is important that the staff encourage discussion of the events which happen between the specific staff member and the specific patient, and that the staff member encourage patients to review between themselves their own differences of opinion with the view of improving communications and thereby increasing tolerance and understanding. In the discussion of problems or events which have occurred outside of the immediate situation, the staff must be reminded of the necessity of not expressing opinions and judgments on situations unless they themselves are aware of the facts and are sure that they are not relying on the patient's interpretation of both sides of the question.

We advise the staff to discourage discussing topics which may be productive of anxiety in either patients or staff. Such topics are for special therapeutic discussion with the psychiatrist or under his supervision. The importance and, at the same time, the dangers inherent in lack of control of this question are quite clearly illustrated by an incident which happened prior to our in-service training period.

A Case Illustration

A teen-age girl had been on the ward for a number of days, but the staff had noticed that she had been increasingly tense during the last two days. One evening a male aide, sensing that she wanted to talk about something, encouraged her to do so. Her immediate response was that she did not want to talk to him because he had to write down everything that she said in the chart and she did not want it in the chart. Motivated by his feeling that she would calm down and retire if she were able to tell him what was "bothering her," he indicated that he could make an exception and not report what she had to say in the nursing notes. One of her early comments, then, was that another girl had told her that she talked about people behind their backs. She claimed that this was an unjust charge and that she was very cross with this girl for maligning her in this manner. She then went on to criticize this girl by implying homosexual activities.

At this point, the aide, possibly being guided by the superficial lay interpretations of psychoanalytic literature, felt that it was the sexual problems which were disturbing her and continued to encourage her to go ahead and talk. As she talked, she alternately criticized patients and personnel and made some fleeting reference to sexual topics. Practically all of the staff on all three shifts, as well as the patients with whom she was living, came in for considerable talking about "behind their backs." The longer she talked, the more tense and agitated she became. The more she was reassured that she was a good person, the more agitated she became. She maligned other individuals, until she finally was screaming that she wished she were dead. Her behavior was alarming enough for the doctor who was in charge of her study at the Center to be called. When he arrived on the floor, she was pacing the corridor in the dayroom. The physician indicated that he would go into her room and that when she felt like it, she could come in. Very shortly thereafter she went into her room and, without any further discussion or conversation, climbed into bed and promptly went to sleep while the physician was sitting there.

We have additional data which suggest that this patient's tenseness was because of her need to cope with unconscious hostility toward her physician and the resulting conflict centering around her usual method of expressing such hostility by maligning the object of the aggression to other individuals. Her initial response to the aide of indicating that she could not talk to him because he had to write down what she said could be interpreted as her indication that she did want to talk but that this talking behind people's backs was something that she also didn't want to do, and she was resorting to what she understood to be a rule of the floor to protect her from this activity. However, in the interest of what he thought was helping the patient, the aide indicated his ability to

ignore the rules set down by the group and thus broke through her defense. In going ahead and discussing sexual and other problems with him, she also was expressing some of her hostility and aggression toward her physician by the implication that the aide could help her more with this than the physician. This apparently also contributed to her guilt because, when her physician did come to the floor and did indicate that he was not angry or making any demands upon her, she was able to relax and fall asleep immediately.

How easy it is to overlook the simple everyday activity which is causing the trouble while we search for more dramatic causes!

The Value of Nonverbal Relationship

Our staff members are becoming increasingly aware of the real value of the presence of another person on a nonverbal basis. They are also aware of the fact that encouraging discussion of a situation by asking questions may very often be interpreted by the patient as a hostile or aggressive act from which he will find it necessary to defend himself. On the other hand, a comment expressing the staff person's opinion or reaction to a certain situation may very often be considered as something given to the patient by the staff person, and the patient may benefit therefrom.

We are learning what has been known for some time by every boy scout—do not move the patient until there is an appraisal of the extent of the injury. The skilled first aider does not "treat" the injury but tries to give the patient warmth and support and tries to prevent further extension of the damage.

Staff Must Retain Individuality

The staff members at times become concerned over the fact that their attitudes in relationship to the patients may differ from individual to individual. It is important that staff members realize that their most important asset in their interpersonal relations is their ability to be individuals and react in a manner which is consistent for them. They must also realize that it is up to them to indicate to the patients that they cannot expect identical reactions from all staff personnel. Staff personnel learn with experience that a negative response to a patient's request is not an aggressive act toward the patient. A mother who will not let her child drink a glass of coal oil is being thoughtful and considerate, whereas one who permitted her child to do this would be being aggressive.

It is also very reassuring for the staff members to realize that they can be basically honest with their patients. The problem is knowing how. "Won't it spoil my relationship with the patient if I tell him I don't like him?" He'll think you're crazy if you tell him you enjoy his aggressive, annoying, or ugly behavior. However, it is usually quite helpful to take the attitude that "it is what you do that I dislike, not you."

The more we can understand each other, the more we can understand patients. There is a great danger that we reserve what we know of the dynamics of behavior for our patients and overlook the fact that these same dynamics apply as well to ourselves, our colleagues and neighbors.

We know that patients experiencing intense anxiety are quite likely to revert to more primitive mechanisms or patterns of behavior in an attempt to deal with this anxiety. It is probably some such mechanism which repeatedly impels the staff in the direction of attempting to control patients by domination. Even with patients as disturbed as some of ours, the staff must rely on controls from within the individual rather than feel that the external forces or pressures which they can bring to bear are the significant factor.

Most of us are able to put aside some of our uglier or less efficient means of coping with anxiety situations under minor stresses and bring them out only under times of more severe stress.

In retrospect, it was quite amusing to the staff to picture themselves attempting to force a bathroom door which had been barricaded by 2 teen-age patients and to reminisce over the fact that their own anxiety had prompted them to attempt to regain control of a situation which they actually could not regain until the patients themselves had decided to voluntarily relinquish control.

The staff members need to realize that the patients really don't want to be in full control but neither do they want to feel that control is completely and utterly denied them. Also, firmness, tolerance, and patience must not be replaced by barter, bribes, or threats.

The Function of Administration

From the point of view of administration, we have had occasion to observe the truth of the fact that *administration's chief function is to provide a setting in which the staff can operate with a minimum of anxiety.*

Fear of criticism and censure is one of the greatest causes of anxiety in a staff and one of the quickest ways of setting the staff against patients because the patients become a threat to the staff.

Fear of criticism and censure nurtures mistrust and lack of faith between staff members. Since lack of faith in oneself and in others is a basic problem with every disturbed individual, such an individual is quick to recognize it and exploit it in others. The result is, of course, an increase in the anxiety of the patient when he feels he has convinced himself that he cannot depend on people to protect him from his own hostile impulses.

Just as psychiatrists have found that they can be most helpful to the parents of adolescents by dealing with the anxieties of the parents which contribute to the parents' ambivalence which is so confusing to the adolescents, we see the function of psychiatric administration as providing a setting in which the staff can function with a minimum of anxiety.

It is important that a mechanism be set up whereby disturbing events can be studied by the staff in retrospect in order to get the development and progress that can come only from hindsight. However, it is important that any sincere action on the part of any conscientious staff member—no matter at what level he functions—should receive constructive rather than critical appraisal by colleagues and supervisors.

Finally, it has been necessary to recognize that people go into various types of work because of conscious and unconscious needs to obtain certain satisfactions from the work. It is a function of administration to provide the optimum satisfaction of personnel needs within the setting of meeting the patients' needs.

For example, everyone in the field of psychiatry has a need to learn about the problems other people are having in living in order to find some solace or understanding of his own problems. The staff members can learn by observing a patient handling a problem and thus obtain satisfaction in their work. On the other hand, the satisfaction o a need to dominate by the substitution o barter or bribe in place of firmness, toler ance, and patience is not in the best interes of the patient.

Staff Organization Scheme

With regard to the organization and struc turing of the interpersonal situations on th ward, we have evolved the following genera plan. For purposes of more vividly describ ing this organization, we like to compare it to a family situation. The patients, then, become the children in this family situation. The aides become the older siblings or relatives who have a degree of authority as delegated to them by the nursing staff. The nurse on each floor is comparable to the mother in the family situation and has general responsibility for all of the activities of the patients while they are in the Center. The physician in charge of the patient or the floor, however it may be, has a role comparable to that of the father in the family situation. He has a special relationship with the patient apart from that of the nurse. As far as the activities of the patient when the physician is not around, the physician supports the authority of the nurse. The physician does not issue any orders except through the nurse. The occupational therapy staff, the volunteers, and the social service and psychology staff are then in the role of school staff, neighbors, teachers, and other generally helpful individuals who work in close cooperation with the nursing staff.

The administration assumes a role comparable to the police, the government, or the authority outside of the immediate home and represents that which the doctor, the nurse, and the patients see as something necessary and beneficial, although at times restricting in its functions.

In very broad terms, we see one of the major functions of our social service staff as that of interpreting the needs of the patient to his external environment and of interpreting the needs of the environment to the patient.

Our job at the Diagnostic Center has been particularly difficult because of the lack of definitive response to the diagnostic formulation during the short period of stay at the Center. Our staff has to deal with the difficult transitional behavior but has to re-

lease the patient before beneficial results can be observed. We see the dress rehearsals but not the real performance.

It is gratifying to our staff, and I am happy to be able to report to you, that follow-up reports to date indicate that some of the patients who were most difficult to manage before coming to the Center and while at the Center are doing well in their own homes, foster homes, or institutions.

135 West Hanover Street.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1956, the March of Medicine began its eleventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	12:15 p.m.
WHSA	Brule	Friday	10:30 a.m
WHKW	Chilton	Friday	10:30 a.m
WCHF	Chippewa Falls	Saturday	9:45 a.m.
WHWC	Colfax	Friday	10:30 a.m
WHAD	Delafield	Friday	10:30 a.m
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Friday	10:30 a.m
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	5:00 p.m
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	1:00 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Friday	10:30 a.m
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:45 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Friday	10:30 a.m
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	11:00 a.m.
WBKV	West Bend	Saturday	11:15 a.m.
WHLA	West Salem	Friday	10:30 a.m

The Management of Ureteral Stone*

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Introduction

ONE of the frequently seen urinary tract lesions is ureteral stone. Not infrequently, difficulties arise in its management. This thesis is written to define clear concepts in its clinical management.

Formation and Composition

Ureteral stone rarely forms within the ureter itself but, rather, is found in that position by virtue of its expulsion from the renal pelvis. On rare occasions stone may form in a ureteral diverticulum, or calcareous depositions may form on ureteral lesions if the passage to the bladder is unusually impeded.

Ureteral stones vary in chemical composition, the most common being calcium phosphate, calcium oxalate, and uric acid stones. They may be single or multiple. They are more common in men, and the highest incidence is in the age groups 20 to 30 and 50 to 60. Most of the stones are radiopaque; but a few, notably uric acid, xanthine, and cystine stones, are apt to be radiolucent.

Diagnosis

A typical ureteral colic due to stone is rarely mistaken for any other condition. The sudden onset of severe pain, beginning in the costovertebral angle and radiating over the iliac crest to the lower abdomen, is classical. As the stone progresses downward, the pain is frequently referred to the genitalia or to the inner aspect of the thigh. The pain is intense, sometimes shocking in nature, and frequently associated with nausea and vomiting; and it usually requires narcotics for relief. As the stone approaches the lower end of the ureter, particularly the intramural part, frequency of urination may occur. Hematuria, gross or microscopic, is usually present. Tenderness of varying degrees, depending upon the degree of obstruction to the ureter, is present in the costovertebral angle. Few patients with a history of ureteral colic recollect recovering their stone.

The attacks of colic are intermittent, and the first is apt to be the most severe. With increasing frequency, patients are seen who have had intravenous urograms with their first or subsequent colic; in the past it was not uncommon for the diagnosis of ureteral stone to be made on a purely clinical basis.

X-ray Diagnosis

The majority of stones cast a shadow, but it is important to emphasize that some stones are radiolucent. Not infrequently stones overlying the bony pelvis are visualized only with difficulty or are not visualized at all. Satisfactory ureterograms may demonstrate a negative shadow. We are all aware of the extraneous factors that at times increase the difficulty in demonstrating stones — defects in the cassette, water spots on the film, ingested seeds and bone, bird shot, and medications. Besides these, there are enteroliths; phleboliths; pigmented moles; calcified lymph glands; calcified ovaries; gallstones; and calcifications of other organs, particularly blood vessels. Varying degrees of ileus may occur, making x-rays difficult to interpret.

Differential Diagnosis

The diagnosis of ureteral stone is usually not difficult if the picture follows a classical pattern. However, any patient with abdominal or back pain not easily explained should have a urinalysis and intravenous pyelocystograms. Irrespective of the condition for which a patient is being treated, if the urine contains pus, blood, or albumin, a urologic investigation is indicated. In the female, the urine for study should always be a catheterized specimen. The second glass of a two-glass test is adequate for a study of male urine. An x-ray diagnosis of stone in the ureter should include oblique films so that the stone, whether it be a radiopaque or a negative shadow, is definitely localized in the ureter. Not infrequently shadows in the line of the ureter prove to be extraureteral when oblique films are made.

Ureteral colic may on occasion be produced by inflammatory disease within the

*From the Department of Urology, Deaconess Hospital, Milwaukee. Read before the Delta County Medical Society, Escanaba, Michigan, Oct. 25, 1955.

ureter, ureteral cysts, or edema, and must be distinguished from ureteral stone itself. In highly sensitive individuals, ureteral colic may be produced by ureteral spasm of unknown origin. Blood clot or showers of crystals traversing the ureter may also produce colic.

Ureteral colic must be distinguished from acute appendicitis; diverticulitis; tubo-ovarian disease; and, on occasion, gallbladder disease, although gallbladder colic is more apt to simulate renal colic. On rare occasions stomach or duodenal disease or pain referred along the course of spinal nerves may produce a picture simulating colic.

The pyelogram may or may not reveal the presence of stone, depending on the stone's opacity and its location in the ureter. Varying degrees of hydronephrosis or spindle dilatation of the ureter are usually present. There is also some degree of tenderness on fist percussion in the involved kidney. On occasion, no contrast medium is eliminated from the involved side. At times ureteral colic may be shocking to the patient.

Subsequent colics may be less intense; and on occasion patients with ureteral stone may exhibit the clinical picture of pyelonephritis or pyonephrosis with hard chills and fever. Reflex anuria may occur, although this is a very rare phenomenon. Occasionally, evidence of renal failure may be present in those patients with a long-standing history of bilateral stones and infection.

It is important to emphasize that intra-abdominal lesions may coexist with ureteral stone. We recently observed a patient with a retrocaecal appendix overlying the ureter in whom the picture was essentially that of ureteral colic. It seems reasonable that when the physician cannot readily obtain pyelograms, and acute appendicitis seems to be the diagnosis, appendectomy is indicated.

Treatment and Management

This logically can be divided into three steps: (1) treatment of the immediate problem; (2) making some attempt to determine the etiology of the stone; and (3) employing measures to prevent stone re-formation.

The treatment of patients with ureteral stone falls into three categories: (1) medical noninterventive management; (2) cystoscopic manipulation; and (3) surgical removal of the stone. The determination of the procedure to follow is based upon various factors. Each case should be individualized.

Stones may be classified according to size, location, number, and composition. Small stones are those an eighth of an inch or less in diameter, and large stones are those above one-quarter of an inch in diameter. It is well to remember that the x-ray slightly magnifies the size of any stone, approximately 15 to 20%.

The patient who has a colic; whose urine is substantially free of infection; and whose x-ray shows a small or medium-sized stone in the lower part of the lower third of the ureter, with little or no hydronephrosis and drainage of urine past the stone, is an ideal candidate for masterful nonintervention. When the patient first visits the family physician, it is best that the physician not make a statement such as, "The urologist will insert an instrument into your bladder and remove the stone." A patient so informed expects that statement to be a fact, and may become suspicious of the urologist's ability if he decides on noninterference.

A cooperative patient may be observed for weeks or months without there being any undue harm to the upper urinary tract. He is instructed to have a large fluid intake, approximately three to four quarts of liquid in 24 hours. His urine is studied frequently for unusual evidence of infection. He is given morphine or a comparable preparation with the instruction that if he feels the slightest inkling of a colic, he should take a tablet of morphine and lie down. The morphine may be repeated as often as necessary to relieve pain. He is instructed to urinate, even during times of bowel evacuation, into a container. A quart milk bottle is excellent. The stone is recovered if at all possible. Even with these instructions, many patients pass stones that are never recovered.

The progress of the stone is watched carefully by x-ray, the intravenous pyelograms being repeated if any doubt exists regarding drainage of urine or infection in the kidney. Clinically, lack of drainage is manifested by pyuria, fever, and renal tenderness. Drugs other than narcotics—such as the various pituitary preparations—are not apt to be of unusual value in stimulating ureteral peristalsis. Morphine is probably the drug of choice. If the urine is chemically normal and contains only three or four pus cells in an uncentrifuged specimen, small doses of a urinary antiseptic such as one of the sulfa drugs may be employed.

It is well to emphasize that this treatment requires an understanding, intelligent patient who cooperates in his care. It is also well to emphasize that the proof of the passage of the stone is its actual recovery, with x-ray evidence of its disappearance. It is unwise and unsafe to treat ureteral colic due to stone and not keep the patient under observation. It is well to inform the patient of the dangers to his kidney if the stone is not passed. Not infrequently, patients are seen with advanced pyonephrosis requiring nephrectomy. These patients have had an initial colic and have been subsequently free of pain, and on that basis assumed that either the stone had been passed or was insignificant. It is also this type of patient who so frequently is treated for various gastrointestinal disorders, including appendicitis. Urinalysis and an x-ray of the abdomen may arouse suspicion of the presence of a urologic disorder.

The decision to interfere with a stone either by open surgery or cystoscopic manipulation, is predicated upon various factors. In a general way it might be said that the following are indications for surgical intervention:

1. The presence of a stone that is obviously so large it cannot traverse the ureter. All giant ureteral stones fall into this category, as well as most stones classified as large.

2. The presence of most stones, irrespective of size, impeded in the upper two-thirds of the ureter and of many stones impeded in the lower third of the ureter. The patient who previously has passed a stone may frequently pass another stone of comparable size. Also, in the patient who has a typical colic, and whose x-ray reveals an essentially nonobstructive stone in the last half inch of the ureter, there is probably a capacity of the stone to readily move down the ureter. It is well to emphasize that pregnancy complicates ureterolithotomy; and after three months' gestation, such an operation may be hazardous. The patient, then, whose stone shows little evidence of movement becomes a candidate for surgery. Regarding this, it is most important to emphasize the necessity for x-ray observation just prior to the time the patient is placed on the operating table. Movement of a low-lying stone may alter the surgeon's decision to interfere. Also, because a stone is capable of the unpredictable, the surgeon should be aware of its exact location so that hours are not lost searching for a stone that has passed into the bladder or again moved upward into the kidney. In this regard, the gentlest of handling of the ureter is important, since stones readily move up a dilated ureter. Therefore, in surgical exposure it is well to carry the dissection immediately down to the stone, if possible. A Babcock or Allis forceps, above and below the stone, holds it fixed until it can be removed. It is also important that the ureter not be freed any more than is necessary, that a catheter be passed up and down the ureter, and that interrupting sutures be made around the drain to adequately drain the wound in a direct position. A wound closed too tightly does not allow for good drainage of urine. The drain is straightened the second postoperative day and then allowed to remain unchanged for four or five days, after which it is slowly extracted each day.

3. Presence of reflex anuria. Unilateral stone with urinary suppression is rare. We have observed but two such cases. The basis for this is not clearly understood. Both cases occurred in patients in whom the colic was near shocking in nature. Provided the stone is very small, a single attempt to pass a ureteral catheter might be tried; but no undue hesitation should be permitted if urinary secretion does not promptly reoccur.

4. On rare occasions, the presence of uncontrollable pain may necessitate surgical removal of the stone.

5. The presence of ureteral stone with suppression of urine on the involved side is best treated by surgical removal of the stone.

6. The presence of pyuria, chills, or fever indicates pyelonephritis. It is an indication for ureterolithotomy.

Cystoscopic Manipulation

Stone extractors are mentioned only to be condemned. Injury to the ureter, with subsequent stricture, infection, perforation, or even the actual inability to remove the instruments, has been reported. We believe it might fairly be stated that the surgeon unfamiliar with ureteral surgery is most apt to resort to cystoscopic manipulation, although some expert cystoscopists have gained unusual experience and judgment in the use of this method. In their hands, complications are quite on a par with surgical complications. However, few urologists have had conclusively happy results with stone extractors. In the hands of those who clearly understand the indications and limitations

of the extractors, their use is sometimes justified.

Cystoscopic manipulation is usually reserved for cases in which there are small stones that remain hung in the lower inch of the ureter, and where there is infection of the urine or associated suppression of the urine on the involved side. Under these circumstances cystoscopy should not be done in the office. Rather the patient should be hospitalized and given adequate medical treatment. Then, under spinal anesthesia, an attempt is made to pass one or more ureteral catheters past the stone. This eliminates spasm and promotes drainage; and, frequently, after 48 hours the stone will be passed. If not, another attempt might be made to reinsert catheters, increasing the dilatation if possible.

During the course of the patient's management, inquiry is made into his dietary and fluid intake habits. The urine is completely studied; and, at the completion of the period of observation, every attempt is made to secure a sterile urine. Some patients will never become infected; but, particularly in those who have had manipulation, varying degrees of infection are quite common.

On occasion, infection itself may be the basis for stone formation. It is well to emphasize that infection and urinary stasis form the basis for the majority of urinary tract stones; unless these factors are corrected, the reoccurrence of stone is common. Stone of recumbency is occasionally seen. Hyperparathyroidism has rarely been found. Colloidal imbalance is probably a factor in patients with bilateral stones. Cystine calculi are rarely seen. Prolonged alkaline management such as is necessary in ulcer patients predisposes to stone. Each case is surveyed, with chemical analysis of the stone. In selected cases, detailed chemical studies are done on the urine and blood.

It is well known that stasis and infection, or both, are frequently present and require correction. Frequent cultures and sensitivity studies on the urine are done so that time is not lost in ineffective use of medications. Probably the best assurance of prevention of stone re-formation is an adequate output of urine, which should be 1,500 to 2,000 cc. daily. This washing of the urinary tract at least decreases the degree of stone enlargement. Also, patients are instructed to take one multivitamin tablet a day, except during the months of July and August. It is important to emphasize that it is not the fluid intake but, rather, the urinary output which is significant; and in extremely hot weather enormous fluid intake may be necessary in order to secure a larger urinary output. A few patients have been placed on hyaluronidase or Amphojel.

Summary and Conclusions

The etiology and classification of ureteral stone is briefly mentioned. The diagnosis of ureteral stones is discussed, and the necessity for either the recovery or x-ray evidence of stone is emphasized. Also stressed is the importance of urinalysis and of elimination of infection and stasis, which is necessary in order to prevent stone re-formation. A large urinary output aids in this prophylactic measure and of necessity must be a daily occurrence. Good fluid intake habits are necessary.

In obscure abdominal lesions, particularly with the presence of blood or pus in the urine, ureteral stone must be considered. The coexistence of intra-abdominal lesions with ureteral stone occasionally occurs, and in such cases immediate attention is necessary. However, as soon thereafter as possible, the urinary tract should be evaluated.

The treatment selected is predicated upon the size and location of the stone. All stones in the upper two-thirds of the ureter, and some in the lower one-third, are removed surgically. Chills and fever, anuria, or oliguria make cystoscopic drainage or surgical intervention mandatory. With a cooperative, intelligent patient, it is sometimes possible to merely keep him under observation until the stone is passed. This is particularly true if the previous experience of a patient justifies such management. Many patients are seen in whom the ureterogram shows a very small fragment of stone very near, or impeded at, the ureteral orifice. Such stones will almost always pass without interference.

Cystoscopic manipulation, particularly with stone extractors, may induce infection and actually produce perforation of the ureter. An attempt is made to prevent stone re-formation, and the importance of periodic urinalysis is emphasized to the patient. Stress is laid upon a good urinary output, particularly in the summer months. Each case is individualized so that the morbidity and complications are reduced to a minimum.

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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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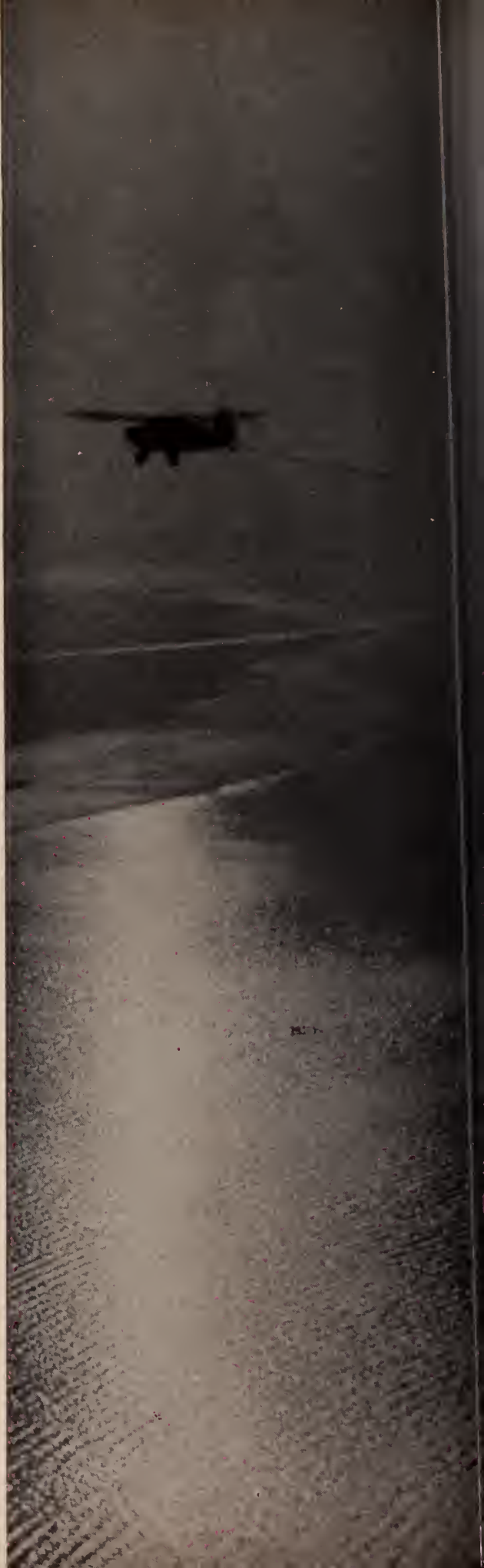

ACHROMYCIN ACHROMYCIN

Interpolated Vascular Grafts

By H. B. BENJAMIN, M. D., MARVIN WAGNER, M. D., ROBERT MANN, M. D., WALTER ZEIT, Ph. D., JOSEPH KUZMA, M. D., and R. K. AUSMAN*

Milwaukee

Introduction

USE of prosthetics in the replacement of vascular defects, especially in the aorta, has made great strides in the past decade. Current medical periodicals contain numerous articles stressing surgical procedures concerned with the restoration of the continuity of injured or thrombosed blood vessels. Vein and artery transplants, metal tubes, and plastic and glass cylinders have been used to bridge vascular defects.

It is only proper to mention the pioneers in this new and important field, for it is because of their monumental work that others have been encouraged to take up the challenge of this project. The cornerstone of this entire work may be the various experimental transplants performed by Carrel and Guthrie in 1906.[1] It was Guthrie who, in 1919, first concluded that the applied graft temporarily restores physical integrity and that it acts only as a cast upon which the host vessel can lay down its own tissue for the permanent bridge necessary to complete the continuity of the defective blood vessel.[2] Credit must also be given to surgeons who experimented with the use of materials actually foreign to the body for vascular bridges. Donovan used polyethylene tubes associated with anticoagulant medication in vascular injuries,[3] whereas Hufnagel employed methyl methacrylate in his studies of the intubation of the thoracic aorta.[4] The use of human vessel grafts and their mode of presentation must be credited to such excellent workers as Gross, Deterling, Swan, and Pate.[5–8] Blakemore, Voorhees, and D'angelo also added an excellent contribution to the field of reconstructive vascular surgery by their use of Vinyon cloth as a vascular substitute.[9,10]

Thrombosis has been the major problem. This has been the common denominator to all investigators. The problem of thrombosis becomes more exaggerated with the use of cloth and plastic prosthetics. The extremely flexible or collapsing type of vessel substitutes cause wrinkle thrombosis as described by Wesolowski.[11] Edwards and Tapp[12] styled the braided nylon tube, which actually is a conventional nylon shoe lace adapted to use as a plastic blood vessel bridge (fig. 1). The fabric was chemically treated so that it could be cut to any desired length and facilitate the use of arterial sutures without causing fraying and, most important of all, prevent encroachment on the intraluminal diameter. Crimping the tube gave it flexion rigidity. The resultant cylindrical tube was firm but resilient, and maintained its shape even when flexed 180 degrees.

Fig. 1—Chemstrand cloth and tubes.

Material and Methods

Chemstrand nylon filament yarn of 210 denier braided by the Essex Mills was used in the experiments. The tubes were of varied diameters. The tube used was of the same calibre as the segment of aorta to be replaced. The Chemstrand Corporation made three different types of tubes: (1) plain straight, (2) crimped, and (3) siliconized. Twelve mongrel dogs were used in this experiment of replacing a portion of the abdominal aorta by tube prosthesis. Because of the excellent qualities of the crimped tube, we employed it in all but one dog. All dogs were anesthetized with intraperitoneal veterinary Nembutal. Under sterile conditions the aorta was exposed through a left paramedian incision. The aorta was freed from

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the distal trifurcation up to the renal vessels. The grafts were prepared by moist sterilization. Employing Blalock clamps, a segment of the aorta was replaced by an artificial crimped tube aorta of like size. The ends of the graft were butted to the ends of the aorta and held in place by a continuous suture of 5–0 braided arterial silk. The anastomosis completed, the distal Blalock clamp was removed first. This step is important as it tests the graft under lower pressure. The proximal clamp was removed if no leaks occurred. If hemorrhage occurred at the sites of the anastomosis, the bleeding was usually controlled by gentle pressure for a period of from three to eight minutes. There must not be disproportion in the intraluminal diameters of the graft and the aorta. The use of a graft either smaller or larger than the aorta led to hemorrhage because of poor apposition, and we feel that this is a great defect in this procedure.

After three minutes, all seeping through the tube wall stopped. All our animals were given 300,000 units of penicillin prophylactically over a five-day period. The grafts on the exposed aorta were peritonealized and the femorals were checked for pulsations. Early exercise to stress the grafts produced no untoward effects. If the internal diameter of the graft was reduced, the dogs remained inactive and refused to exercise.

Pathological Discussion

The need for vascular replacements is obvious. The available material used for grafts can be improved; even the vascular bank grafts are deficient in materials for handling one or another of the many vascular defects. The plastic crimped tube is the best substitute at this time. The irregular surface of the crimped tube has never caused intravascular thrombosis. A post-mortem examination performed on a dog that died following surgery because of an injury to the small intestine showed a smooth, fibrous lining in the lumen of the tube graft (fig. 2).

Dogs were sacrificed at different time intervals, and microscopic sections were made of the tube grafts. Microscopically, the artificial aortic graft sections showed the woven artificial material covered on the external surface by closely applied connective tissue containing blood vessels, nerve bundles, and

Fig. 2—Crimped graft in place. It was removed the fourteenth postoperative day.

adult fat. In several areas there was an inflammatory reaction characterized by polymorphonuclear cells and minute zones of necrosis. There was some inflammatory cell infiltration present in the adjacent fat and vessels, both veins and arterioles. On the internal aspect of the graft there was a prominent layer of fibrin which was nonpigmented. On the side nearest the graft substance, here and there were foci of fibroblasts. The fibrin layering was rather dense, but its organization was quite sparse except at the proximal and distal ends of the graft.

We employed the crimped tube in our vascular replacements almost exclusively because it could be anastomosed so easily and led to fewer postoperative complications. We also found that it was unnecessary to splint the suture line with nylon ribbon as was suggested by Edwards. Like other investigators in this field, we found that postoperative complications followed when there was a disparity between the lumen of the graft and that of the recipient aorta. Attempts to reduce the size of the donor graft by wedging or to increase its lumen by dilating led to disastrous results. If the donor graft was cut so that the approximating ends were crests instead of troughs, the suturing of the graft to the recipient vessel could be performed with greater ease.

Summary

The use of an inert tube to replace a segment of blood vessel in our series of animal experiments proved highly successful. But we feel that this is but a step in the right direction. Although Edwards has advanced

this work and improved the outlook in the use of prosthetics for vascular replacement, especially by the introduction of the crimped tube which can be used in flexion areas, we are still searching for a good vascular substitute. A good blood vessel substitute must fulfill the following requirements:

1. It must be a tube that is readily available.
2. It must adapt itself readily.
3. It must be a tube that can be tailored to the size of the host vessel.

This tube must be available and tailored to size at the time of the operation. We must not be dependent on vascular banks, whose supply is all too often inadequate.

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REFERENCES

1. Carrel, A., and Guthrie, C. C.: Uniterminal and biterminal venous transplantations, Surg., Gynec. & Obst. 2:266–286 (March) 1906.
2. Guthrie, C. C.: End-results of arterial restitution with devitalized tissue, J.A.M.A. 73:186–187 (July 19) 1919.
3. Donovan, T. J.: Uses of plastic tubes in reparative surgery of battle injuries to arteries with and without intra-arterial heparin administration, Ann. Surg. 130:1024–1043 (Dec.) 1949.
4. Hufnagel, C. A.: Permanent intubation of thoracic aorta, Arch. Surg. 54:382–389 (April) 1947.
5. Gross, R. E., Hurwitt, E. S., Bill, A. H., Jr., and Peirce, E. C., II: Preliminary observations on use of human arterial grafts in treatment of certain cardiovascular defects, New England J. Med. 239:578–579 (Oct. 14) 1948.
6. Coleman, C. C., Jr., Deterling, R. A., Jr., and Parshley, Mary S.: Experimental studies of preserved aortic homografts, Ann. Surg. 134:868–877 (Nov.) 1951.
7. Swan, H., Robertson, H. T., and Johnson, M. E. Arterial homografts; fate of preserved aortic grafts in dog, Surg., Gynec. & Obst. 90:568–579 (May) 1950.
8. Pate, J. W., and Sawyer, P. N.: Freeze-dried aortic grafts; preliminary report of experimental evaluation, Am. J. Surg. 86:3–13 (July) 1953.
9. Blakemore, A. H., and Voorhees, A. B., Jr.: Use of tubes constructed from Vinyon "N" cloth in bridging arterial defects—experimental and clinical, Ann. Surg. 140:324–334 (Sept.) 1954.
10. D'angelo, G. J., Benson, W. R., and Grimson, K. S.: Vinyon–N cloth tube for bridging arterial defects, A.M.A. Arch. Surg. 70:39–44 (Jan.) 1955.
11. Wesolowski, and Sauvage, L. R.: Comparison of face of orlon mesh prosthetic replacement of thoracic aorta and aortic bifurcation, Clinical Congress, 1954, Nov. 15–19.
12. Edwards and Tapp: Personal communications to the authors.

THESE GUIDES MAY HELP YOU

The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

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Triplets Born to Primigravida

By HOMER M. CARTER, M. D.
Madison

Introduction

TWO instances in which triplets were born to 22-year-old mothers in their first pregnancies are presented here.

Statistics of births in the United States show that twins occur approximately once in every 85 to 90 births, triplets occur once in every 7,500 births, and quadruplets occur once in every 400,000 births. Furthermore, in multiple pregnancies, it is known that in at least 25% of the cases, one or more of the fetuses die in utero and, of the 75% born alive, many do not survive the newborn period, chiefly due to prematurity.

From 1906 to 1952 Beacham of New Orleans reported 15 cases of triplets. Of these:

4 only were in primiparae
1 mother had had twins previously
24 (of the possible 45 babies) were either stillborn or died in the neonatal period due to prematurity
Short labors were the rule (usually under six hours)
None of the pregnancies went beyond term (39 weeks was the longest)
20% of the mothers had toxemia
3 mothers had hemorrhages and manual removal of the placenta
6 only delivered spontaneously
17 babies survived of 24 born alive (17 of a possible 45).

Because of the probability of complications either in the pregnancy or in the labor of a multiple pregnancy case, the woman who is either suspected of having multiple pregnancy or is a proved case of multiple pregnancy should be more frequently seen by her attending physician than the usual pregnant woman.

Multiple pregnancy usually occurs in multiparous women over 30 years of age and with an hereditary background in which there is a history of twins, triplets, etc.—either on the father's or mother's side, or on both sides.

Case Reports

After this brief introduction, we would like to present a report on two sets of triplets.

The first set was born to a 22-year-old gravida I in July, 1949. They were identical twin boys contained in one chorion with separate amniotic sacs and a girl enclosed in the usual single amnion and chorion.

In this case the pregnancy was comparatively uneventful. The mother, wife of a student, was 5 feet, 6 inches in height and usually weighed 145 pounds. She weighed 175 pounds at the end of 33 weeks, when she went into a spontaneous labor of one and three-quarters hours, terminating in the delivery within 20 minutes of two boys and one girl weighing 3 pounds, 11 ounces; 3 pounds, 12½ ounces; and 3 pounds, respectively—a total weight of 10½ pounds for the three.

The mother's blood pressure tended to be elevated (122/76 to 148/90), and occasional slight edema of the legs and ankles was present. Twins were suspected during the sixth month; an x-ray was taken and revealed triplets. As stated above, delivery occurred at 33 weeks. A right mid-episiotomy was performed. Outlet forceps were used to deliver the first child from the right occipitoanterior presentation; the second child was a spontaneous left occipitoanterior presentation, and the girl was extracted as a double footling presentation.

The mother had an uneventful puerperium and, as far as we know, these triplets are healthy 7 year olds today.

* * *

The second set of triplets was born in June, 1955, to another 22-year-old gravida I who was a healthy young farm wife, herself a twin. She was 5 feet, 5½ inches in height and usually weighed 150 pounds; she had gained to about 173 pounds when she delivered at term. This mother was referred by her local physician because of some doubt as to the diagnosis. Normal pregnancy or extrauterine pregnancy or other causes for bleeding were considered. From the patient's last period in September, 1954, to late November, pregnancy was questionable; and she had many irregular pains in the back and abdomen. There was a "show" at 3½ months. After this time she progressed

normally, having a systolic pressure of 100 to 142 with no edema.

At six months twins were suspected because of the patient's symmetrically enlarged abdomen. At seven and one-half months two hearts were heard. The x-ray revealed triplets—all with the heads presenting toward the vaginal outlet.

False labor occurred. At eight and one-half months mild attempts to induce labor were made as the patient was very uncomfortable and one head had been low in the pelvis for one month with mild "pains" starting. The patient returned home after 24 hours in the hospital with no labor having started.

At 39 weeks—practically at term—the patient entered the hospital at noon. Her blood pressure was 160/95. After an enema, and administration of 2 ounces of castor oil and later quinine by mouth, labor of five hours resulted in the delivery within 25 minutes of identical triplet females, all being contained in one chorion with a separate amnion for each child. After a right mid-episiotomy, low forceps were applied to the right occipito-anterior presenting first child, which weighed 5 pounds, 9 ounces. The two others followed spontaneously as left occipitoanterior and right occipitoanterior presentations and weighed 4 pounds, 12 ounces and 3 pounds, 9 ounces, respectively. The total weight was 13 pounds, 14 ounces. There was one large placenta, and there was a minimum of vaginal bleeding.

There was neither postpartum uterine atony nor postpartum hemorrhage in either of these two cases. There was a history of 12 sets of twins in the background of each case.

It is not unusual to experience the delivery of twins in a moderately large obstetrical practice. It is a rare circumstance, however, to attend two very healthy young mothers in their first pregnancies who successfully come to delivery and give birth vaginally to living, healthy triplets. All six of these children are now normal and well—three of them at 7 years and three at 1 year.

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SUMMER CAMP FOR DIABETIC CHILDREN AT LAKE GENEVA

A summer camp for diabetic children will be opened for the eighth season under the auspices of the Chicago Diabetes Association, Inc., from July 15, 1956, to August 5, 1956, at Holiday Home, Lake Geneva, Wisconsin.

In addition to the complete camp personnel, there will be a staff of resident physicians and dietitians trained in the care of diabetic children.

Boys and girls ages 8 through 14 years are eligible. For further information regarding fees, interested persons should write or phone the office of the Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are urged to notify parents of diabetic children and to enter the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

THE CHICAGO DIABETES ASSOCIATION
5 South Wabash Avenue
Chicago 3, Illinois
ANdover 3-1861

Limited capacity requires prompt application.

Comments on Treatment

Editor—HARRY BECKMAN, M. D., Marquette University, Milwaukee

What drug has been used in a new type of therapeutic approach to recalcitrant cases of Stokes–Adams syndrome?

The answer is sodium lactate. Samuel Bellet and associates,[1] of Philadelphia, reported that this drug as used by them restored ventricular beating during repeated episodes of cardiac standstill in Stokes–Adams seizures and increased the slow ventricular rates in varying grades of partial A–V heart block, sinus bradycardia, and complete A–V heart block.

In one patient in whom ephedrine sulfate, Neo-synephrine, and atropine were ineffective in controlling ventricular standstill, and thumping the chest and electric stimulation only restored cardiac contractions temporarily, half molar lactate consistently restored ventricular beating on 10 different trials and uniformly increased the idioventricular rate. The increase in rate depended on the amount and rapidity of the administration and was maintained from one to four hours after infusion was discontinued.

Another patient with terminal cardiac arrest received 17 cc. of molar lactate intravenously in about one minute. The heart beat was restored and continued as long as artificial respirations were maintained. Sodium lactate was effective in this case in increasing the rate of ventricular beating in each of three successive periods of anoxia. There was no change in the inherent rhythm, and the complete A–V block persisted.

One patient with complete heart block had a ventricular rate of 15 per minute, had widened QRS complexes, and was in shock. Lactate increased the ventricular rate to 60 per minute in this patient and blood pressure to 120 to 140 mm. of mercury systolic. The patient's clinical condition improved markedly, and the widened QRS complexes were narrowed. Decreasing or stopping infusion on two occasions returned the heart rate to 15. After five hours of the lactate infusion, the ventricular rate increased to 60 per minute and was maintained without further treatment. About an hour later, normal sinus rhythm returned.

In a second case of A–V heart block, ventricular and atrial rates were increased by administration of sodium lactate. In a third case, idioventricular beats were abolished and replaced by normal beats.

Sodium lactate probably does not increase the heart rate through a typical sympathomimetic action in these Stokes–Adams cases since it has not been observed to do so in either normal men or experimental animals; there is some evidence of slight vagolytic action in the dog but not much in man. Bellet's group feels that the chief effects may be due to the alkalosis or the direct effect of the sodium ion and probably the lactate ion on cardiac muscle. They consider that since sodium lactate is capable of increasing cardiac rhythmicity with little or no pressor action, it should be helpful in preventing and treating cardiac standstill. No ectopic rhythms were produced in their cases.

Dosage in this small series of patients ranged from 15 cc. of molar sodium lactate (11.2 per cent) administered in about one minute to a total of 960 cc. (molar and half molar solution) administered within a period of five hours, rapidity of injection depending upon the urgency of restoring the heart rate.—HARRY BECKMAN, M. D.

REFERENCE

1. Bellet, Samuel, Wasserman, Fred, and Brody, Jerome I.: Treatment of cardiac arrest and slow ventricular rates in complete A–V heart block; use of molar and half molar sodium lactate: a clinical study, Circulation 11:685–701 (May) 1955.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Walter H. Jaeschke, M. D.

Clinic on Orthopedic Tumors

(Clinic planned by members of the University Hospitals Tumor Clinic, Madison, and Dr. Henry Okagaki, Division of Orthopedic Surgery. Presented on March 19, 1955.)

Dr. H. Okagaki: We have selected for our orthopedic clinic 4 young people with primary bone tumors. All of the patients have been observed for a period of several years, and all have been treated with conservative or relatively conservative measures. Clinical laboratory studies have been noncontributory.

Pain, swelling, or limitation of motion of some skeletal part were the symptoms which worried the parents and prompted them to bring the children to the offices of their local doctors.

It would be interesting and informative for the fourth-year medical students of this audience to have a discussion concerning the classification of bone tumors. A variety of classifications of varying complexities have been proposed, but time will not permit us to go into this subject today. I would like to call to their attention, however, the excellent material in Geschickter and Copeland's book, *Tumors of Bone*, published by J. B. Lippincott Company, Philadelphia, Pennyslvania, and in Lichtenstein's book, *Bone Tumors*, published by the C. V. Mosby Company, St. Louis, Missouri.

Case 1

Dr. C. Blunck: This 16-year-old boy was considered well until June, 1951, when he bumped his right knee and some pain and swelling developed. There was no roentgenogram study. Months later, on about February 10, 1952, he fell and hyperflexed his knee on the thigh. Immediately thereafter, swelling was noted again; and the boy was unable to extend his knee or to bear his weight. Under anesthesia the knee was extended and was placed in a cast to the midthigh. Roentgenograms revealed disease of the upper tibia, at first interpreted elsewhere as possible tuberculosis. The cast was kept in place for five months.

When the patient was admitted to Children's Orthopedic Hospital on June 27, 1952, the knee was found to be slightly enlarged and tender and to have a 15-degree flexion deformity. Tuberculin tests were negative.

Dr. H. Okagaki: The roentgenogram of the knee (fig. 1a) seen in the view box reveals an expansive, centrally located lesion involving the epiphysis of the right tibia. The cortex is intact, and the center has multiple areas of rarefaction resembling cystic bone tumor.

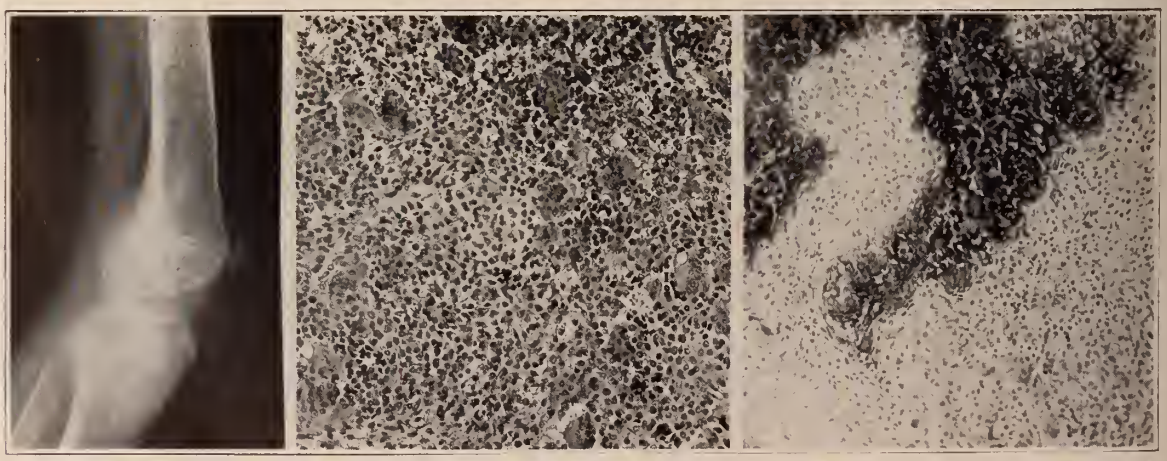

Fig. 1—Case 1. Left, Benign epiphyseal chondroblastoma. Lesion in region of epiphysis of right tibia. Cortex intact. Multiple areas of rarefaction resembling cystic bone tumor. Center, Microscopic showing, embryonic chondroblasts, little or no intercellular chondroid, and giant cells. Right, Microscopic showing, fine lines of beginning calcification and distinctive zones of degeneration with heavy calcification.

On July 3, an exploratory arthrotomy was done on the right knee, and a bone tumor was removed from the upper tibia.

Dr. W. Jaeschke: Fragments of bone and a grayish, rather gelatinous-appearing tissue were received in the laboratory. Microscopic preparations indicate that the lesion has a varied histologic pattern. In some fields (fig. 1b) a cellular stroma with many giant cells provides an appearance which can lead to the erroneous diagnosis of giant cell tumor. Other areas are highly cellular and are largely composed of embryonic chondroblasts with little or no intercellular chondroid. A very striking feature in many fields is the presence of faintly discernible bluish areas of beginning calcification and distinctive zones of degeneration with heavy calcification (fig. 1c).

It is interesting to note that such a tumor is often confused with a giant cell tumor and that both Ewing and Codman considered them variants of a giant cell tumor. Jaffe and Lichtenstein in 1942 introduced the term, benign epiphyseal chondroblastoma; and it is this term which finds the most favor in the literature of today.

We would like to stress that this tumor is seen most often in young males under 20 years of age, while genuine giant cell tumors are seldom encountered before the twentieth year.

Codman made special mention of the occurrence of this tumor in the region of the tuberosity of the upper end of the humerus. It should be pointed out, however, that it also occurs in the epiphyseal ends of other bones before epiphyseal cartilage has disappeared, particularly in the femur and tibia.

Doctor Okagaki: Some workers have contended that this lesion rarely, if ever, becomes malignant; others have disagreed with this view. We have been particularly concerned in this case because, at the time of the present follow-up admission, January, 1955, the patient was shown to have a recurrence. Tumor was found at the site of previous surgery and in some of the surrounding soft tissue. The histology is no different than before, and it is for this reason that we have not considered amputation. Giant cell tumors occasionally show an escape into surrounding tissue after breaking the capsule during surgery; we are suggesting that the same has taken place in this case.

We must continue to see this boy at regular intervals.

Case 2

Dr. D. Taylor: This boy was 6 years of age when first seen in the clinic of the Children's Orthopedic Hospital (September, 1953). His parents explained that he had developed a limp six months before and that it was associated with a gradual swelling of his right ankle.

Palpation confirmed the changes in the ankle, but it also indicated the presence of tumor masses in the distal and proximal ends of the right fibula.

Dr. H. Okagaki: A roentgenographic skeletal survey showed normal-appearing bones on the left side of the body. On the right side the bones of the upper extremity were also normal, but multiple tumors were found in the pelvis and leg. There was a large mass of the right ilium adjacent to the sacroiliac joint, and there were scattered lesions of the right ischium; also there was a lesion in the upper shaft of the femur producing irregularity of the bone texture and a slight enlargement of the bone. Similar lesions were present in the distal tibia and at either end of the fibular shaft, including the proximal fibular epiphysis. These had caused expansion and irregular loss of bone substance with islands of ossification and with enlarged cartilaginous masses (fig. 2).

Fig. 2—Case 2. Ollier's disease (multiple enchondromata) shown in fibula and lower tibia.

It was concluded that the boy had multiple enchondromata involving the right lower extremity and pelvis and that the condition represented Ollier's disease.

Elevation to the sole and heel of the right shoe was ordered in order to compensate for the difference in leg lengths. No treatment was advised at this time for the enchondromata, but the parents were informed that surgical removal of some masses could become a necessity at a later date.

The boy is now a patient again because of a fall suffered on March 1, 1955. Roentgenographic study shows a fracture in the upper third of the femoral shaft through an area of enchondromatosis. The fracture is in excellent alignment, and a hip spica is being used.

Are there any questions?

Student: Do these lesions undergo sarcomatous change?

Dr. W. Jaeschke: Patients with skeletal enchondromatosis (multiple enchondromata) have lesions which are generally more cellular than the lesions seen in patients with solitary enchondromata. One must keep a careful watch because every so often during adolescence or early adult life one or more tumor sites show spurts of growth indicative of malignancy.

Case 3

Dr. C. Blunck: This boy was 10 years old when seen for the first time on July 31, 1952, at the Children's Orthopedic Hospital. He complained of a painful swelling on the outer side of his right foot (fig. 3a).

Roentgenograms revealed a soft tissue swelling immediately about the fifth metatarsal.

Dr. H. Okagaki: On Aug. 5, 1952, a firm, smooth, rubbery mass was found encircling two-thirds of the shaft circumference of the fifth metatarsal. Although the mass was easily dissected from the overlying tissue, no definite line of demarcation from the periosteum could be established (fig. 3b). Consequently, the entire fifth metatarsal was excised as well as a thin layer of cortex from the lateral aspect of the base of the fourth metatarsal which appeared to be involved. The fifth toe was left intact.

The boy was seen on several occasions during follow-up studies and was found to walk without a limp. Because of the presence of some induration in the old operative site, I thought it best several days ago to take a biopsy specimen.

Doctor Jaeschke, would you please discuss the tissue changes in this case.

Dr. W. Jaeschke: The microscopic preparations of the 1952 specimen show a tumor composed of delicate, spindle-shaped cells with some tendency to arrange in bundles (fig. 3c). Actually, the histologic pattern in some fields has features noted in a desmoid of the abdominal wall and in a tumorlike condition of the plantar fascia known as plantar fibromatosis. It is tempting to consider a diagnosis of plantar fibromatosis in this case, but the surgeons are insistent that the lesion had absolutely no connection with the fascia.

The presence of mitotic figures in some fields, and definite information concerning the location of the lesion, leads us to a diagnosis of periosteal fibrosarcoma.

I am happy to say that the biopsy specimen from the old operative site shows no return of the tumor.

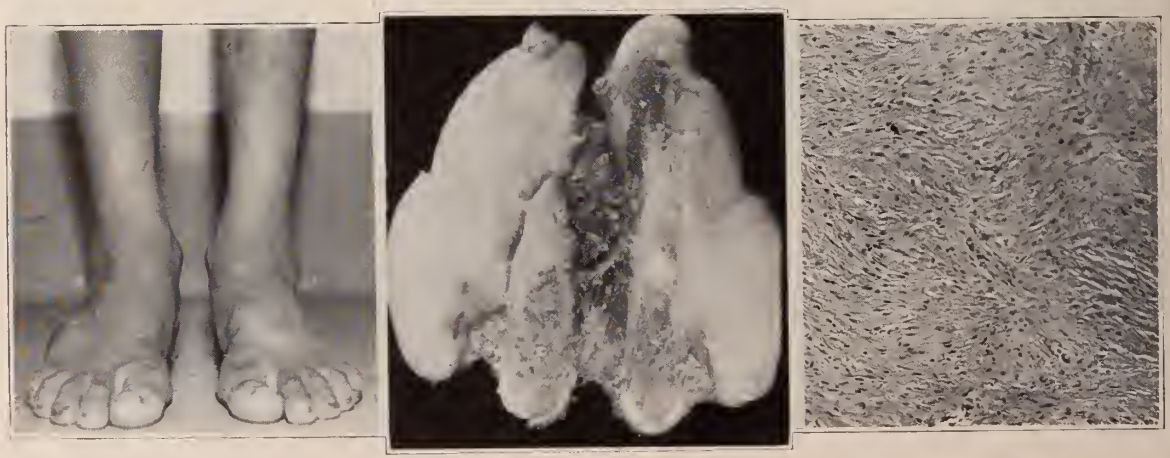

Fig. 3—Case 3. Left, Periosteal fibrosarcoma of right foot of a 10-year-old boy. Center, The gross specimen. Right, Microscopic view.

Important to this case is the knowledge that periosteal sarcomas are relatively uncommon, have a rather low-grade malignancy, exhibit a rather slow rate of growth, and rarely metastasize even after incomplete surgical extirpation. Stout of Columbia University reported metastasis in only 1 of his 13 cases. Eight of his cases developed in bones other than the long bones, notably the scapula, the mandible, the sacrum, and the coccyx.*

Case 4

Dr. D. Taylor: Tommy was 7 years of age when he was seen for the first time on Sept. 26, 1952. His parents explained that he had had a limp for one and a half years and that more recently he had complained of pain in the right knee.

Examination revealed a somewhat stiff hip gait on the right. With the hip in abduction there was a loss of 20 degrees of internal rotation as compared with the left. There was no loss of length, and there was no atrophy of the thigh.

Dr. H. Okagaki: You see in this roentgenogram (fig. 4) a good-sized cystic lesion in the neck and proximal shaft of the right femur extending across the intertrochanteric line. The neck is slightly expanded. The cystic area approaches to within a centimeter of the epiphyseal line. There is evidence of pathologic infraction at the intertrochanteric area, duration undetermined.

On Oct. 4, 1952, under general anesthesia, an excision of the lesion and a packing of bone chips were accomplished.

Dr. W. Jaeschke: Small bone fragments and pieces of greyish-yellow tissue with a gritty consistency were received in the laboratory. The microscopic preparations showed scattered spicules of new bone together with a fibrous connective tissue with varying degrees of cellularity (fig. 5). There were several focal areas of hyaline cartilage.

Our diagnosis was monostotic fibrous dysplasia, an imperfectly understood and apparently non-neoplastic lesion occurring most frequently in older children and young adults and most commonly found in ribs, femur, tibia, and maxilla. According to Schlumberger of Ohio State University, lesions of this

Fig. 4—Case 4. Monostotic fibrous dysplasia. A good-sized cystic lesion in neck and proximal shaft of right femur.

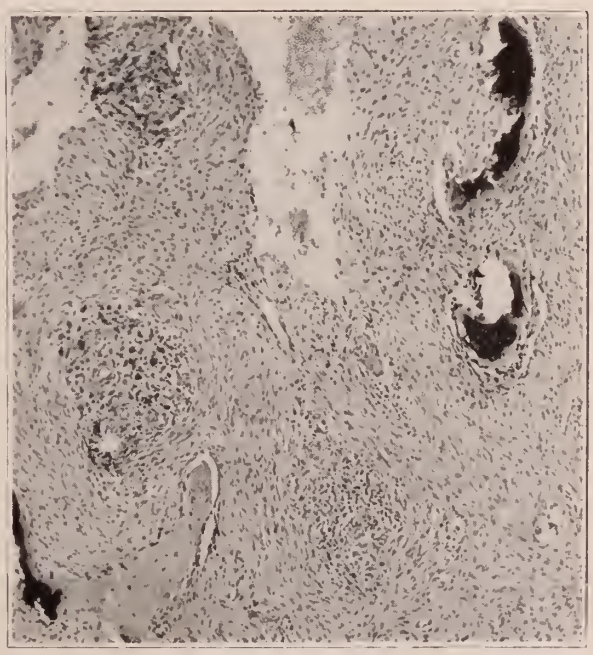

Fig. 5—Case 4. Microscopic preparation of monostotic fibrous dysplasia in right femur.

*The boy was seen again in December, 1955, and was found to have a recurrence. Histologic study showed a more active lesion than before. The foot was removed on Jan. 3, 1956.

type are often associated with a history of trauma. They are not to be confused with the nonrelated polyostotic lesions which are usually associated with endocrine dysfunction, precocious puberty in females, and skin pigmentary changes (Albright's syndrome).

It is important for roentgenologists and pathologists especially to recognize this condition. Incorrect diagnoses, sarcoma especially, have been made on numerous occasions in the past.

Doctor Okagaki: This boy returned to the hospital on Jan. 8, 1955, and complained of a return of some pain in the hip. Further surgery was carried out to eliminate a small focus of cystic rarefaction proximal to the fused mass of bone chips.

We expect to observe him at intervals.

UNIVERSITY OF MICHIGAN CONFERENCE ON AGING

The University of Michigan's ninth Annual Conference on Aging will be held at the Michigan Union and University Hospital in Ann Arbor, July 9–11. The conference theme will be "Health for the Aging," medical and social services.

CONFERENCE HIGHLIGHTS OF SPECIAL INTEREST TO PHYSICIANS

Sessions	*Speakers or Chairman*
Addresses	
Healthy Added Years	E. L. Bortz, M. D.
Major Issues in Providing Medical Care for Older People	Nathan Sinai, Dr. P. H.
The Battle Against Chronic Disease	L. T. Coffeshall, M. D.
Trends in Gerontology	William B. Jountz, M. D.
Panel Discussions	
Meeting the Costs of Medical Care for the 65 Year Old and Over	Odin Anderson, Ph. D.
Trends in Health Legislation for Older People	L. E. Burney, M. D.
Research on Health and the Aging Process	Ralph W. Gerard, M. D.
Physicians' Clinics	
1. Arthritis in the Older Age Group	William D. Robinson, M. D.
2. Hypertension and Other Vascular Problems in the Older Age Group	Sibley Hoobler, M. D.
3. Orthopedic Problems in Relation to Arthritis and Vascular Diseases	Sylvester O'Connor, M. D.
4. Dermatological Problems in Old Age	Arthur C. Curtis, M. D.
5. Organic Brain Disorders in the Older Age Group	
6. Psychological Problems of Older People	
7. Hyper- and Hypothyroidism	
Demonstrations	
Planning for Discharge and Continued Care at Home	James W. Rae, Jr., M. D.
Seminars	
Undergraduate and Graduate Medical School Teaching and Hospital Training Program in Geriatric Medicine	E. V. Cowdry, M. D.
Health and the Aging Process	Ralph W. Gerard, M. D.
Workshops	
1. Integrated Medical and Social Services	Arnold Kurlander, M. D.
2. Health Criteria for Retirement	To be Announced
3. The Geriatric Clinic in the Hospital and in the Community	Samuel Gertman, M. D.
4. Health Assessment of the Aging	S. David Pomrinse, M. D.
5. What Older People Should Do to Maintain Their Own Health	Panels of Michigan State Medical Society Geriatric Committee
6. Planning New Housing and Long-Term Care Facilities	John W. Cronin, M. D.
7. The Problem of Mental Illness Among the Aging	Raymond Waggoner, M. D.
Films	
"Still Going Places" (Physical Restoration)	
"The Cold Spring Idea" (Role of Education)	

Make room reservations through the University of Michigan Extension Service, Ann Arbor, Michigan.

Restaurant Sanitation

As It Looks to Your State Board of Health

ALMOST every urban family today has at least one member who regularly eats one or more meals away from home on five or more days of each week. Some of these people carry lunches prepared in their own homes, but many more patronize their favorite restaurants.

You, as a physician, are well aware of the ever-present danger of food-borne disease outbreaks and food poisoning. Severe outbreaks are quite well reported and usually thoroughly investigated; however, it is a frustrating truth that by the time a severe food-borne disease outbreak is recognized and reported to the local health department or the State Board of Health, it is too late to do anything but investigate to determine the cause of the outbreak and record the facts. Just how many of the cases of upper respiratory disease and gastrointestinal disease not reported to the health department can be blamed on poor restaurant sanitation is an unanswered question. The number may be considerable. To protect the public from the danger of food- and water-borne disease, food poisoning, and communicable disease, the State Board of Health has adopted and rigorously enforces minimum standards for public eating establishments and provides a continuous training program for restaurant operators and food handlers.

During the past two years certain changes in operating procedures effected by the State Board of Health with the assistance of the 1953 state legislature have brought about a rather marked improvement in restaurant sanitation in Wisconsin. These changes have made it possible to report that a very high percentage of Wisconsin restaurants now maintain sanitary standards which equal or exceed those required by the State Board of Health. The legislative changes made it possible to double the number of public health sanitarians employed and authorized the Board to designate city health departments with qualified, full-time sanitarians as their agents in the enforcement of state regulations. New, improved standards have been developed and are in the process of adoption. Enforcement of standards, except for suspension of permits, has been decentralized to the district and municipal level, making for much greater efficiency, more rapid follow-up, and a much higher percentage of compliance with Board regulations.

Good restaurant sanitation is achieved first through the education of food handlers, using the method of conducting group instruction for the food handlers as well as using the inspectional visit as a teaching opportunity. Second, good restaurant sanitation is achieved through the judicious application of police power, the summary suspension of restaurant permits by order of the Board, and closing of the restaurants with the cooperation of the local district attorney in those few cases where restaurant operators ignore the public safety and do not comply with the orders of the Board.

A restaurant, as legally defined in Wisconsin, includes any place where meals are served to the general public, including, with minor exceptions, taverns and soda fountains which serve meals. The definition as it has been interpreted by the attorney general does not include: private clubs serving meals to their members; churches which serve meals to organizations pursuant to previous arrangements, on terms not available to the general public; caterers who sell and serve meals to private parties, clubs, or church organizations pursuant to previous arrangements, on terms not available to the general public; or food stores and delicatessens which sell food by the pound, quart, or dozen rather than by the meal.

During 1955, all of the 12,665 restaurants in Wisconsin were inspected one or more times. On the first inspection, 16% of these restaurants were found to have violations of major public health significance; that is, such things as an unsafe water supply, unsatisfactory refrigeration, ineffective or inadequate dishwashing and sanitizing facilities, unsafe facilities for food storage, or unsafe and unsatisfactory methods of operating such equipment. Two-thirds of the unsatisfactory conditions found had been corrected by the time a follow-up visit was

made, which usually was within 30 days of the original visit. The balance of the restaurants with major violations corrected the violations before the end of the grace period allowed by the state restaurant sanitarian or, in a few cases, were reported to the Board with the recommendation that their permit be summarily suspended. It was necessary in only four instances during 1955 for the Board to suspend the permits of restaurants to operate and to secure the closing of the restaurants through the cooperation of the local district attorney.

The public health sanitarians of the Board have been trained to utilize the inspectional visit as an educational opportunity so that the restaurant operator learns the public health reason behind the Board's regulations and is, therefore, more willing to see that they are complied with. He also learns what it can mean to him from an economic standpoint if he operates his restaurant in a sanitary manner. Experience has repeatedly demonstrated that restaurants which serve wholesome, well-cooked food in clean, attractive surroundings on properly sanitized dishes, and employ neat, clean, and efficient waitresses will soon be rewarded by having far more than their proportionate share of the community's restaurant business and far less of the problems and headaches attendant to the operation of an insanitary restaurant.

When you eat out, make it a point now and then to ask to see the kitchen; the restaurant operator with a clean kitchen is always proud to show it to his customers. Compare the kitchens you see in Wisconsin restaurants with those in other states and then let us know how you would rate your Wisconsin restaurants. We invite your criticism and your suggestions for improvement. —E. H. Jorris, M. D., *Assistant State Health Officer.*

PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected re-registration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana write immediately to the office of the Director of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect re-registration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

APPLICATION FOR CERTIFICATION

Applications for certification, American Board of Obstetrics and Gynecology, for the 1957 Part I examinations are now being accepted. Candidates are urged to make such applications at the earliest possible date. The deadline date for receipt of applications is Oct. 1, 1956.

All candidates for admission to the examinations are required to submit with their application a plain typewritten list of all patients admitted to the hospitals where they practice for the year preceding their application or the year prior to their request for reopening of their application.

Application for re-examination, as well as requests for resubmission of case abstracts, must be made to the secretary prior to Oct. 1, 1956.

Current bulletins outlining present requirements may be obtained by writing to:

Robert L. Faulkner, M. D., *Secretary*
American Board of Obstetrics and Gynecology
2105 Adelbert Road
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4. **Recovery from severe trauma or burns.**
5. **Nutritional care in wasting diseases such as carcinomatosis and tuberculosis.**
6. **Domiciliary care of decubitus ulcers.**
7. **Care of premature infants.**

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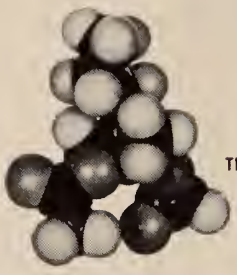

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THE MEDICAL FORUM

SPECIAL REPORT ON MEDICAL SOCIETY MEETING

Annual Meeting a Big Success; More Than 3,100 Attend Various Sessions in Milwaukee

Milwaukee—The State Medical Society's 115th Annual Meeting is now history, and it will be remembered as one of the most successful sessions in the organization's long record of service.

Registration totaled 3,176, including 1,684 member physicians. There were 33 physicians from out-of-state, 902 guests and 133 senior medical students. Attendance at the 1955 meeting aggregated 2,468.

DEANS SPEAK

The Delegates heard **Dr. Carl N. Neupert**, State Health Officer; **Dr. John Z. Bowers**, dean of the Wisconsin Medical School; **Dr. John S. Hirschboeck**, dean of the Marquette School of Medicine and others speak on a wide range of pertinent problems.

Dr. Neupert had praise for Wisconsin's *"high level of health services, availabality of good hospitals, work of the Society's Committee on Maternal and Child Welfare in lessening hazards of childbirth, the state's immunization program and efforts in preventing and controlling preventable diseases."*

He said:

"We must concentrate on conquering chronic diseases, our principal cause of illness and death. We must work against a lag between research findings and application of that knowledge."

Dr. Neupert said one of the biggest causes for concern was a shortage of funds, "which is threatening public health programs in Wisconsin.

ACTION NEEDED

"Public health personnel are becoming discouraged . . . If I didn't believe things would improve, I would be discouraged, too. Pious hope won't be enough. We need action."

Dean Bowers said medical schools *"need more money, for salaries, research and general operating purposes."*

Another problem, he said, was the practice of medicine by members of medical school faculties.

"This is a problem simply because few medical schools can afford to pay salaries sufficient to hold full-time men," Dean Bowers said. "All medical schools are trying to meet this problem by getting additional funds to pay better salaries . . . and thus maintain the good relations between the practicing profession and our medical schools."

LARGE CLASS

United States medical schools will graduate over 7,000 physicians within the next year, he added.

Dean Hirschboeck asked that men in active practice *"think kindly toward your medical school. Give it the support it needs, help morally and financially. Unless we take the leadership in supporting our schools, they might fall into hands we would not care to have them fall into.*

"Be sympathetic toward our needs."

Dean Hirschboeck likened medical education to a three-ring circus, the rings being education, research and service, and they "should be kept in this order: education, first and foremost; research, second and service third. The functions must be kept in proper order . . . or the tail will wag the dog."

AUTHORITIES REPORT

Special reports were presented by **Dr. Robert F. Purtell**, Milwaukee, on the fetal-neonatal study report; **Dr. W. B. Hildebrand**, Menasha, on the use and distribution of the Salk polio vaccine; **Dr. R. H. Wilson**, president of the Minnesota Medical Society and **Dr. W. S. Jones**, president of the Michigan State Medical Society.

Report Closer Ties in Blue Shield Planning

Milwaukee—Plans for closer coordination of sales, research, claims and statistical problems for all Blue Shield Plans in the 10th District were reported by **Dr. J. W. Fons**, Milwaukee, at the Annual Meeting.

Dr. Fons, speaker for the House of Delegates and 10th District chairman, said he anticipates greater coordination between the Plans of Wisconsin, Iowa, Nebraska, North Dakota and Minnesota in the future.

NOTICE!

Actions of the House of Delegates at the State Medical Society's 115th Annual Meeting in Milwaukee May 1–3 will be printed in full in the August issue of *The Wisconsin Medical Journal.* The report will include committee reports and complete details of the session. **Watch for it!**

Physicians Told to Awaken to Civil Defense Needs, to Battle Apathy

Milwaukee — Wisconsin physicians must get in and pitch on civil defense preparations!

That was the message brought by the Reference Committee on Reports of Standing Committees to the House of Delegates at the Annual Meeting.

REPORTS STUDIED

The Committee considered a number of reports, including the one from the Committee on Civil Defense.

Dr. G. W. Carlson, Appleton, chairman of the Reference group, read:

". . . while civil defense may never be completely ready to cope with every eventuality, both the medical profession and the public must wage a constant fight against apathy and make every effort to be as prepared as possible for disasters."

The House approved his committee's report which read, in part:

1. The mobile medical team plan should be retained. (This is part of a plan worked out by the State Civil Defense organization and the Society's Committee on Civil Defense). Two physicians be designated as captain and co-captain of each team. In the selection of these physicians county medical societies which have not done so are advised to follow the example of those societies that have been most successful, by soliciting volunteers who are interested rather than assigning physicians purely on a mandatory or duty basis. These individuals should be given the responsibility by their county medical society of designating a team business manager and maintaining a close liaison with local, county and regional civil defense officials; being fully acquainted with procedures in event of disaster; and maintaining a special interest in medical aspects of civil defense and casualty care. They would have full knowledge of supplies, transportation and operation of their teams in event they were called into action.

C. D. MANDATORY

2. Since in 1955 the legislature approved a new civil defense law making it mandatory for every town, city and county to have a civil defense group, physicians are obligated to learn the fundamentals of disaster planning and familiarize themselves with the plans of local civil defense directors.

3. The assistant co-director of health services in state civil defense should continue his excellent work in assisting with the organization of medical teams. Increasing attenion should be devoted to educational efforts among the team captains and business managers.

The Committee on Civil Defense, working with the state civil defense staff, developed a plan for 100 mobile medical teams, each with 29 members captained by two physicians. Four attempts to build these teams to full strength have faltered short of the goal. The Committee said it had found "next to impossible to obtain and sustain the interest of 2,700 laymen and 200 physicians in peacetime."

Foundation Maps Active Future

Milwaukee—Twenty-nine of 52 county medical societies were represented at the first meeting of the Trustees of the Charitable, Educational and Scientific Foundation Inc., of the State Medical Society in Milwaukee.

A recommendation that each practicing physician in Wisconsin contribute $10 or more annually won approval of the House of Delegates.

Dr. Ervin L. Bernhart, Milwaukee, Foundation president, told the Delegates that the organization *"is already beginning to demonstrate its practical value to the public health of Wisconsin and to the medical profession."*

To prove his point, Dr. Bernhart listed these projects:

1. A $100,000 plan to restore Ft. Crawford Military Hospital in Prairie du Chien as a medical museum for Wisconsin.

2. The pledging of several thousand dollars by at least two Wisconsin industries to undertake scientific studies in the areas of hearing trauma and geriatric factors in health insurance.

3. Establishing of annual awards for scientific papers by physicians doing residencies in Wisconsin hospitals.

4. A move to set up roadside marking of sites having significance in medical history.

New Members Briefed At Annual Meeting

Milwaukee — New members of the State Medical Society, guests at a luncheon meeting during the Annual Meeting in Milwaukee, were briefed on a variety of significant subjects, ranging from insurance coverage to improved public relations.

After talks on the Society and the American Medical Association, **Atty. Norman Skogstad,** Milwaukee, offered some tips for bettering public information efforts and preventing malpractice suits. Legal aspects of practicing medicine were outlined in detail.

DR. DESSLOCH SPEAKS

Speakers included *Dr. E. M. Dessloch,* Prairie du Chien, Chairman of the Commission on Prepaid Plans; *Atty. Robert B. L. Murphy,* Madison, Society counsel; *W. C. White,* assistant secretary of the Society; *Dr. Ervin L. Bernhart,* immediate past-president of the Society and *T. A. Hendricks,* Chicago, secretary of the AMA Council on Medical Service.

Name Mrs. Baumann Auxiliary Pres.-Elect

Milwaukee—The Woman's Auxiliary of the State Medical Society, which now has a membership of 1,606 in 34 organized county groups, selected **Mrs. A. J. Baumann** of Milwaukee as president-elect.

Mrs. Baumann will take office next May, succeeding **Mrs. H. W. Christensen,** Wausau, present head of the organization. The immediate past-president is **Mrs. J. J. Boersma** of Green Bay.

OFFICERS CHOSEN

Mrs. S. B. Russell, Eau Claire, was chosen first vice president; Mrs. M. A. Bailey, Fennimore, second vice president; Mrs. J. W. Boren Jr., Marinette, third vice president; Mrs. John T. Sprague, Madison, recording secretary and Mrs. G. J. Schulz, Union Grove, treasurer.

The Auxiliary was credited with contributing much to medicine's public relations with nurse recruitment programs, participating in community health programs, contributing to the American Education Foundation and other allied projects.

Ask SMS Correlate Post-Graduate Work in Wisconsin

Milwaukee—The House of Delegates asked the State Medical Society to act as the directing and correlating body for all medical post-graduate work carried on in the state.

The action, which came at the Society's Annual Meeting here May 1–3, followed a report by Dr. S. A. Morton, Milwaukee, chairman of the Council on Scientific Work.

DIFFERENT APPROACH

Dr. Morton, who said a "new and dynamic" approach to medical education is in the making in Wisconsin, called attention to the wide range of post-graduate education being carried on at present under sponsorship of the medical schools, medical societies and voluntary health agencies.

Six steps were proposed for implementation of the program, to be under direction of the Society's General Council and the Council on Scientific Work, as follows:

1. The Council on Scientific Work to expand its activities to include more than annual meeting and circuit programs.

TO AUGMENT STAFF

2. Additional personnel be added to the Council from the various groups interested in planning post-graduate education.

3. Additional staff help be provided.

4. Investigate the possibility of developing more post-graduate teaching around the hospitals in the state.

5. Re-evaluate county society scientific programs; study the idea of grouping county society efforts in this direction; leave more time for medico-socio-economic matters at regular society sessions.

IN TUNE?

6. Special efforts to correlate educational efforts of voluntary groups in health field.

Dr. Morton told the House:

"Our most important activity (in the Society) is the advancement of the scientific knowledge of our members. Our annual meetings and teaching programs have not changed substantially over the past few years. Are they in tune with the times?"

Dr. Morton

Dane County Medical Society Publishes News-Handling Guide

Madison — Because cooperation between the medical and journalism professions *"is a mutual goal,"* the Dane County Medical Society has published an "Instructional Guide in News Relationships" for its members.

The result of many months of work by the organization's Public Relations Committee, the publication, a 26-page effort, was adopted by the Society's Board of Trustees this spring.

Madison area newsmen, radio and television personnel met with the doctors before the final draft was sent to the printers. Other sources included the American Medical Association's *Principles of Medical Ethics;* the 1956 issue of *The Wisconsin Medical Journal* Blue Book and the State Medical Society's *Council on Medical Service.*

Procedures for the individual physician and the Society to follow in handling news, publicity, features, radio and TV appearances and subject matter are described in the "Guide." Also listed are regulations for use of signs, telephone book listings, advertising and photographs.

The Society provided for establishment of a Dane County Medical News Service, an agency to consist of three physicians. The Service will help members of its County Society in releasing news stories, feature and scientific items to the press, radio, television and other media of the area.

Doctors Urged: "Run for Coroner"

Milwaukee — Wisconsin physicians were asked by the House of Delegates to give serious consideration to running for coroner in future elections.

Because a new law, enacted in 1955, prohibits a funeral director who serves as coroner from burying any person whose death he is required to investigate, many of the 34 morticians in Wisconsin are reported withdrawing from the office within the next few years.

A plan advanced by the State Medical Society and the Wisconsin Bar Association to re-shape the legal machinery for death investigations, replacing the corners with trained medical examiners, remains in a legislative interim committee.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE

policies are not terminated nor are benefits reduced because of age.

T·I·C

TIME

INSURANCE COMPANY

MILWAUKEE WISCONSIN

WISCONSIN PHYSICIANS HAVE WIDE ARRAY OF HOBBIES

Interest in All Sorts of Diversions Reported

Madison—Name just about any hobby, and Wisconsin has at least one doctor spending his few spare hours enjoying it.

To give you a partial list:

Archaeology, Billiards, Coin collecting, Dog-training, Electrifying reed organs, Fishing, Gardening, Hunting, and down the alphabet . . . including:

Mountain climbing, short-wave radio, basketball coaching, making medical jewelry, collecting very old oriental ivory and wood carvings, collecting old pharmaceutical bottles, following the stock market, making decoys, tree farming, serious music, jazz, collecting old coin banks, quarter-horse breeding, ad infinitum.

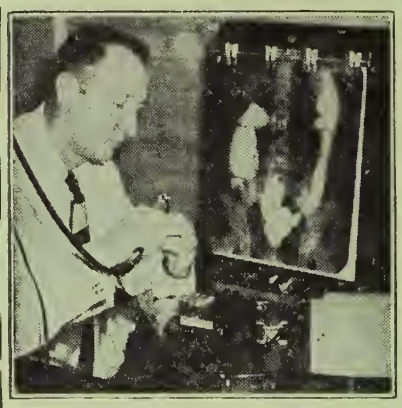
THE STATE MEDICAL SOCIETY'S two feminine mountain scalers, Dr. Maxine Bennett (right) and Dr. Margaret Prouty, both of Madison, are shown atop the Matterhorn in this picture taken in 1949. The height is 14,780 feet.

Undoubtedly the most demanding and hazardous is that of **Drs. Maxine Bennett** and **Margaret Prouty**, of Madison, who utilize vacation periods to scale the peaks in Canada, Switzerland, the United States and Mexico. No mere amateurs, these ladies; they have concentrated fully on learning the techniques of outfitting, gear, conditioning and of course, the actual climbing itself.

Why this sort of avocation?

The two physicians answer:

"How do you explain the fascination of studying weather maps, the anxious listening to the latest forecasts, and after you are finally on your way, how do you describe to the uninitiated the smell of hay in the mountain meadows, the gaudy brilliance of the flowers at high altitudes, and the deep sense of comradeship you share with companions on whose judgment your safety and even your life may depend. You can't analyze the exultation."



MAKING SURE his medical jewelry carries a full degree of authenticity, Dr. R. G. Zach, of Monroe, has an X-Ray picture handy as he produces a new cuff link pattern. His Medical Jewelry Co., followed what started as a part-time hobby.

NOT THE FIRST

They said they are following in the steps of Paccard, the doctor of Chamonix, who scaled Mt. Blanc in 1786.

And there may be other Wisconsin doctors who like to substitute glowing embers for a TV screen, moon and stars for neon lights, singing birds for telephones, campfires for radiators, muscle for motors, pine-needle beds for mattresses.

Dr. Otto A. Backus, of Port Edwards, uses his 175 acres for raising, breeding and training quarter-horses, a comparatively new breed, and to plant and nurture some 12,000 pine trees every year.

"If you've got these same hobbies, call on me," Dr. Backus invites.

The two radio "ham" operators are **Drs. H. William Bardenwerper**, of Waterford, and **E. G. Stack Jr.**, Superior. Dr. Bardenwerper, holder of a Class A license, operates W90LW, and keeps in touch with MD's and others interested in the same form of recreation all over the world. Dr. Stack, who operates W9JAL, also spends time on his gun collection and shooting muzzle loaders.

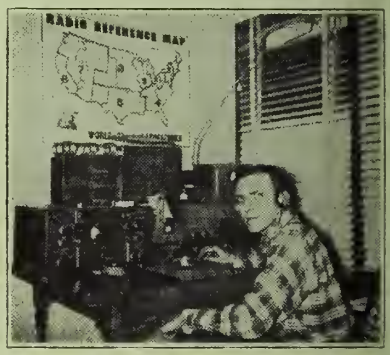
The more than 1600 physicians who attended the 1956 Annual Meeting of the State Medical Society in Milwaukee saw evidence of Dr. R. G. Zach's hobby (it's now a business) of making medical jewelry. Tie-pins were presented to member doctors by Wisconsin Physicians Service, and made a tremendous hit. The clasps featured hand-carved, three-dimensional designs simulating the X-ray films every doctor knows so well.

Dr. Kohn

Dr. R. G. Zach, of Monroe, also makes key chains, cuff links and other gift items in the same manner.

A Milwaukee physician, **Dr. Samuel E. Kohn**, is devoted to his collection of Japanese and Chinese ivory and wood carvings, started almost 25 years ago. The legends, myths and art connected with the folklore valuables go back 12 centuries, in some instances.

(Continued on page 658)



DR. H. WILLIAM BARDENWERPER, of Waterford, is shown at the controls of his short-wave radio, whiling away his free hours. Through this medium, he has made friends in all parts of the world.

Dr. Leonard Reports on Mortality Study Committee Progress

Milwaukee—Dr. T. A. Leonard, Madison, chairman of the State Medical Society's Mortality Study Committee, told the House of Delegates at the Annual Meeting that continuing efforts will be made to bring study facts to Wisconsin physicians.

Dr. Leonard said that efforts of the committee during the past few years have borne fruit, with maternal deaths reduced from 66 in the first year of study to 62 in the second year and 39 in the third. In the same three-year period, obstetric deaths dropped from 39 to 31 to 23.

He said of particular significance was the fact that hemorrhage mortality had been reduced from 21 to 16 to 8, ruptured uteri from 15 to 9 to 1.

Hospital staff and society meetings will be utilized to bring results of the study to physicians, and efforts will be made to develop minimal standards for conduct of good obstetric departments.

"*We wish to continue our work to banish the last vestige of preventable danger to the expectant mother,*" Dr. Leonard said.

PROGRAM OUTLINED

The chairman said his committee worked to emphasize the dangers of convenience inductions of labor; traumatic deliveries and substitution of Cesarean section for endangering procedures from below; version and extraction as a hazard to the mother particularly when performed without adequate relaxing types of anesthesia, and the dangers of manual dilation of the cervix.

He said the committee had advocated:

Correcting laceration of cervix or vagina; in cases of ruptured uterus, the repair or removal of the structure rather than depending on packs of oxytocias as a primary measure;

The use of fibrinogen in abruptio placenta; earlier hospitalization, better stabilization of the eclamptic patient; widening knowledge of the medical complications of pregnany;

Good antiseptic techniques; improving prenatal care; general sharing of knowledge and obtaining of autopsies whenever possible to learn by actualities.

Awakening of Interest in Medical History Noted in Milwaukee

Milwaukee—It was apparent at the Annual Meeting of the State Medical Society in early May that its members are becoming more and more aware of the significance of medical history.

An enthustastic audience listened to officers of the **Section on Medical History** outline plans for the future and make a plea for augmenting efforts in preserving the state's rich medical heritage.

Dr. Millard Tufts, Milwaukee, spoke on "Pioneer Leadership in Wisconsin Medicine," and also turned over a valuable collection of papers of Dr. Ira Manley, Markesan, the Society's 35th president, and Dr. Nicholas Senn, Milwaukee, who were close personal friends.

Dr. William D. Stovall, Madison, who was renamed chairman of the Section, spoke on the development of medical education in Wisconsin. He also cited plans for the coming years, including a mural for the Society headquarters in Madison; restoration of Ft. Crawford Military Hospital in Prairie du Chien; a membership campaign under the direction of the Woman's Auxiliary to the Society and a page of medical history in *The Wisconsin Medical Journal.*

Dues of $5 annually were approved.

Other speakers included Mrs. J. J. Boersma, Green Bay, out-going president of the Auxiliary and Dr. G. Kasten Tallmadge, professor of the history of medicine at Marquette University.

Dr. E. M. Dessloch, Prairie du Chien, and Mrs. S. E. Orth, Madison, were re-elected vice chairmen, and Charles H. Crownhart, Society secretary, secretary and treasurer.

ON THE S.M.S. CALENDAR . . .

JUNE

30–July 1—Commission on Prepaid Plans and General Council, S.M.S.

JULY

3—Claims Committee, S.M.S.

10–12—State Board of Medical Examiners, Milwaukee.

12—State Board of Medical Examiners, with Public Policy Committee, Milwaukee.

25–27—University of Wisconsin Conference on Guidance and Health, Madison.

27–29—General Council and Council on Scientific Work, Land O'Lakes.

AUGUST

7—Claims Committee, S.M.S.

22–24—National Blue Cross–Blue Shield Public Relations Conference, Madison.

Create Committee on Diabetes

Milwaukee—The Council of the State Medical Society, following a suggestion of the Commission on State Departments, created a **Committee on Diabetes** to advise with interested lay groups and to analyze current problems in medical aspects.

The new committee, which also won the blessing of the House of Delegates at the Society's Annual Meeting, will be named by the Council in the near future.

Pamphlet Available

Madison—Copies of "To All My Patients," a public relations pamphlet published by the AMA, are available without charge in the public information office of the State Medical Society.

PSS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

HALO . . .

Another in a series of apt cartoons from a publication entitled IS YOUR HALO ON STRAIGHT is shown below. The HALO series was published for the Ethics and Professional Conduct Council of the Alumni Association of the School of Medicine of the College of Medical Evangelists by San Lucas Press, Los Angeles. It has been described as a "sharp public relations idea, with rapier-like thrusts at physicians who know the shoe fits." HALO shows little fear of treading on toes.

"Who did THAT job on you?"

The Judge

Facts?

Phooey!

All he wants is circumstantial evidence of a different technique.

On that he builds his case—with an elevated eyebrow, a snort of contempt, a sympathetic cluck.

It takes the lid off his id.

From the River Falls Reporter . . .

A doctor in a small town left his ancient Ford in front of a drugstore. On his return he found several youths who customarily loitered on the street corner making merry at the old car's expense.

As he climbed into the well-worn driver's seat, the country M.D. inspected the group carefully, then leaned out and said:

"The car's all right, fellows; it's paid for."

Then the physician pointed to two of the boys, and added:

"You are not!"

State Licensing of Clinical Psychologists Described As "Unwise"

Milwaukee — Opposition to certification by state law of clinical psychologists was expressed by the House of Delegates at the 1956 Annual Meeting in Milwaukee.

The House said it encouraged the **"development of voluntary mechanisms of certification through devices of the clinical psychological group itself."**

This statement was adopted:

"The medical profession respects the learning and dedication of those who have the degree of Doctor of Philosophy in psychology. The fact remains, however, that those who would treat mental diseases are, in fact, treating the sick; and doctors of philosophy in the field of psychology are not trained in the medical sciences.

"The Council and others know that a certification law is but the forerunner of a licensing law. There cannot and should not be different standards under which individuals treat mental disorders."

It was reported that approximately 100 clinical psychologists in Wisconsin are seeking independent certification by state law.

Members of the State Medical Society's Division on Nervous and Mental Diseases agreed that the clinical psychologist "is used in the diagnosis and treatment of individuals with emotional and mental problems or illness; he endeavors to help the maladjusted learn new and better habits of behavior. However, in treating a problem psychologically, there must be assurance that there is not a medical problem which creates the mental problem."

As a result, the Division said, the proposal is regarded as *"dangerous and unwise."*

Doctor!

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation Inc.?

Dr. Poser

Dr. Poser in 61st Year of Practice

Columbus—They used to say Dr. Edward M. Poser had the slickest and fastest horse and buggy team in eastern Wisconsin.

That was soon after he began practice in this Columbia County community in 1895.

He was one of the first to turn to a new and improved mode of travel, the automobile.

Dr. Poser is still practicing. He observed his 88th birthday in late April.

FARMER, TOO

Actually, the distinction of possibly being the *oldest practicing physician in Wisconsin,* doesn't seem to bother the good M.D. He takes it in stride and says he has no intention of retiring from his first love, the field of medicine. He also maintains an interest in two farms he owns.

A graduate of Rush Medical College, Dr. Poser is still active and sees patients daily in St. Mary's Hospital and his office, which he shares with three sons, Drs. Bob, Rolf and Edward F. Another son, Frederick, is an attorney in Hagerstown, Md.

The veteran practitioner established his practice initially in Milwaukee. After a brief stay in Reeseville, he came to Columbus. He served this community as mayor in the early 1900's.

LOVES SPORTS

Enjoying good health, Dr. Poser enjoys an occasional game of cribbage with old friends and retains a love of sports, driving in frequently to Madison to see the Badger football, basketball and boxing teams in action.

His community honored him in 1950 for 55 years of service as a country doctor.

STATE SPOKESMEN SAY REHABILITATION A VITAL ISSUE

SMS Division Learns of Numerous Problems

Madison—How do you define disabilities under Social Security coverage? Does rehabilitation pay off? How do you combat federal restrictions relating to priority of funds appropriated for rehabilitation facilities?

These were only a few of the pertinent problems brought to the attention of the State Medical Society's Division on Rehabilitation at a recent meeting.

Four spokesmen for state agencies outlined current trends, difficulties and plans. They were A. E. Towne, of the Department of Vocational and Adult Education; John A. Kubiak, chief of the State Board of Vocational and Adult Education's Rehabilitation Division; Vincent Otis, of the State Board of Health's Hospital Division and Edward Pfeifer, senior supervisor of the Department of Vocational and Adult Education.

LACK OF UNIFORMITY

Pfeifer said one of the major problems was determining definitions of disabilities under Social Security coverage. This refers to persons seeking to preserve their full rights to coverage while suffering with disabilities. Under federal law, the disabilities must be proven medically.

"There is a lack of uniformity or knowledge of what constitutes disability," Pfeifer said. "It is true that some physicians are unclear in their reports, and some are unwilling to dig deep into an applicant's physical condition. Full evidence is necessary to rule on this freeze. We need complete medical information to do a job.

"It's a matter of interprofessional relations."

DESCRIBE BOTTLENECKS

Pfeifer said his department had a backlog of applications because of hitches in processing the applications, and that the matter of clarifying the reports was the biggest bottleneck.

The Division on Rehabilitation agreed to have the State Medical Society staff work with the department in preparing material for presentation to the group at its next meeting.

Kubiak outlined the workings of his department, and summarized:

"Rehabilitation pays—if the individuals are given a chance. We need more money and personnel but we are convinced we are doing a good job now, all things considered."

PROGRAM OUTLINED

He described current and contemplated projects, including speech therapy classes, vocational centers, homecraft activities, the epilepsy survey, a study of deafness in Wisconsin and programs for the mentally retarded.

Kubiak said his department was gearing its program to provide nine major services, as follows:

(1) Medical diagnosis to learn the nature and degree of disability to determine eligibility for services, the need for additional medical attention and the individual's work capacities;

(2) Medical, surgical, psychiatric and hospital services to remove or reduce disabilities;

(3) Artificial limbs and other prosthetic appliances;

(4) Individual counseling and guidance, including psychological testing, to help select and attain a vocational objective;

(5) Training, including occupational and adjustment help for the blind;

(6) Maintenance and transportation during treatment, training or other phase of the actual rehabilitation process;

(7) Tools, equipment, licenses or initial stocks and supplies if these are needed to give the rehabilitated individual a fair start;

(8) Placement in a job commensurate with the individual's physical and mental capacities, and

(9) Followup to insure that the rehabilitated person is successful and that both he and the employer are satisfied.

Otis said that 1954 amendments to the *Hill-Burton Hospital Survey and Construction Act* included federal grants for rehabilitation facilities, but that appropriations during the past two fiscal years had totaled only $130,000 for Wisconsin.

Major difficulties, Otis said, centered around restrictions relating to eligibility and priority for the funds. He believes federal regulations must be made more flexible to permit a wider variety of projects in the field of rehabilitation in Wisconsin.

Discussion also centered around H.R. 7225 as it pertains to establishment of a disability insurance system for certain persons 50 and over. The bill, passed by the House and scheduled to come before the Senate this summer, was opposed by the Council of the State Medical Society and its view expressed in a resolution adopted in late February.

Dr. Ray Piaskoski, of Wood, Division chairman, suggested the group meet more frequently to be in a position to keep better abreast of matters pertaining to rehabilitation, and this was supported by those present.

House Agrees It Lacks Power to Admit Osteopaths to Open Panel Program

Milwaukee—The House of Delegates agreed with a Council directive that osteopaths be advised that the Open Panel program *cannot* be extended to individuals who are *not* members of the State Medical Society.

Under agreement with the insurance carriers, the Society and the carriers adjudicate problems arising between them through a mediation committee.

The program was initiated to provide injured employees with free choice of their medical attendants and is paid for by the Society, which has no authority to make commitments on behalf of nonmembers.

Through the medium of the agreement, any Society member who indicates his willingness may have his name included on the panel which is certified to the insurance companies. *The plan augments the Workmen's Compensation Act of Wisconsin.*

The House action followed a report at the Annual Meeting that about 160 Wisconsin osteopaths are attempting to participate in the program. They would like their names listed on the panels prepared and distributed by the Society.

HOBBIES . . .

(Continued from page 654)

A lover of the outdoors, Dr. Edwin C. Bach, of Milwaukee, likes to hunt waterfowl, and devised a manner of pulling decoys into position near his blind on the shores of Lake Michigan via a pulley. It's an elaborate, ingenious arrangement, one which helped make a deluxe hunting site out of a rocky, wave-swept escarpment near Port Washington.

"BUTCH" FAMOUS

The effort has paid off in good hunting and good eating. Of equal interest is his training of Chesapeakes, one of which, Butch, has received wide publicity for his skill.

Dr. F. J. Cerny, of Fond du Lac, says his love for serious music *"at times is almost passionate . . . and I believe, with Voltaire, that life without music would be a mistake."*

In addition to playing piano, accordion, oboe (he makes the parts by hand) and organ, he has doubled as personnel manager of the Badger Symphony Orchestra, for which he has played nine years.

Dr. Cerny commented:

"It is said that all oboe players eventually go crazy . . . However, it is my contention that they must be crazy to begin playing it.

"The secret of enjoying the making of music is to recognize one's limitations and to attempt the best within those limitations. The reward is the peculiar combination of inner calms and exhilaration of creating something beautiful, though modest."

A LA ASTAIRE

Dr. Ervin L. Bernhart, Milwaukee, derives much pleasure from informal singing, likes to dance and to listen to American folk music.

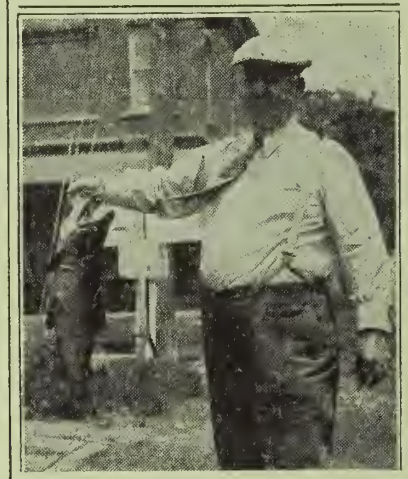
That man often seen walking the range line near Wabeno may be Dr. George H. Reddick who studies archaeology, and attempts to tie in the history of the area before the arrival of the white man with changes in the past two centuries. He is a member of the State Historical Society.

Also interested in music is Dr. James K. Martins, of Eleva, whose hobby is restoring and electrifying reed organs. He did just that for the Sisters at Sacred Heart Hospital in Eau Claire who, we are told, remain fascinated over the splendid job. Dr. Martins also directs choirs in his home community.

Dr. David L. Williams, Madison, played for and coached a city league basketball team for many years, finally giving up the assignments this past winter. Dr. James C. Russell, Fort Atkinson, and Jack Burke, of the Society staff in Madison, are former members of Dr. Williams' teams.

This agile athlete–coach also loves to do wood-working, to take 35 mm. color pictures and raise fruit trees.

Dr. L. O. Simenstad, Osceola, installed as Society president in May, has a love for flying, and regularly travels to meetings in his two-placer. He also is a member of the State Aeronautics Commission.



Dr. Hogan

Dr. Robert E. Terry, Cuba City, describes his interest in an unusual hobby as satisfying and fascinating. He collects relics, which in ecclesiastical terminology, are **"part of the bodies or objects kept as memorials of saints of the Roman Catholic Church."**

LARGE ASSORTMENT

A friend in Rome started sending him relics about seven years ago. He has received, collected and placed over 500 items in chapels and shrines, including such relics as those of the True Cross, the cross of the *"good thief,"* of the apostles, apostolic fathers and doctors of the church, the founders of all the religious orders and a large group of mystics.

The runnerup for the state chess championship when he was only 11, Dr. Ervin Teplin, Milwaukee, continued his interest in this intriguing game. Not a tourney competitor at present, he plays for pleasure, and teaches it to others, including his six and nine year-old sons.

Dr. Teplin's field is psychiatry, and there apparently is a tie-in here. He says the game provides a healthy, constructive outlet for an intellectual pursuit.

In brief, here are a few of the hobbies of other physicians:

Dr. John J. David, Cassville—landscaping, fishing and renovating old furniture.

Dr. J. S. Supernaw, Madison—Photography, wood-working, making jewelry, lapidary, astronomy, hi–fi.

A River Falls M.D.—Woodworking, making picture frames, stamps, collecting old pharmaceutical bottles and artifacts.

Dr. Walter W. Stebbins, Madison—Following the stock market and investments. Also bridge, shuffleboard and pocket billiards.

Dr. T. W. Tormey, Jr., Madison—Collecting antique coin banks.

Dr. R. O. Barnes, Milwaukee—Oil painting and sketching with pen, pencil and crayon; photography and farming.

Dr. John Hogan, of Twin Lakes, is fond of the outdoors, and likes to hunt, fish and participate in field trials, entering his bird dogs. He says he also loves horses and racing.

Drs. S. J. Francois, New Glarus, and C. F. Schroeder, Madison, have taken an active role in coin club activities, and have impressive collections.

Dope Addiction Film Offered By Foundation

Los Angeles, Calif.—The Narcotic Educational Foundation of America is offering a 30-minute sound film entitled *"Dope Addiction, A Medical Hazard."*

The film, in color, attempts to show that the current addiction situation is a problem involving every physician. Narration is by Federal Narcotic Commissioner H. J. Anslinger.

The film is available without cost to local medical organizations, nurses' groups and medical schools. Requests should be sent to the Foundation, Suite Five, 1645 N. La Brea Avenue, Los Angeles 28.

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The Wisconsin Diagnostic Center

In this issue is a description of the operation of the Wisconsin Diagnostic Center and an analysis of the tense emotional situations that grow among patients and staff as its program unfolds. Davis, in addition to providing an intimate glimpse of the workings of this fine clinic, gives considerable insight into the causes for the tension that can be found in any organization run by people.

New techniques that seek solutions to psychiatric problems are being employed there. They promise fruitfulness for the program at the Wisconsin Diagnostic Center and for the future of psychiatry in general.

His discussion of relations among patients and between patients and staff gives a new and different view of problems within a psychiatric clinic.

A section on judgment vs. authoritarian rule is especially noteworthy. It calls to mind an article in the August 26, 1950, *Lancet* on the discussion method in preclinical teaching which explored methods of helping students develop powers of accurate observation, precise speaking, distinguishing a few clear things in a complex situation, expressing similarities and differences in unambiguous terms, and of distinguishing what is really seen from what is supposed to be present. The dictum to the students, "Do not try to guess which formula learned in the past is expected now," expresses a principle that Davis characterizes in other words but with equal force.

The function of administration, explains Davis, is to provide a setting in which the staff can function with a minimum of anxiety and the optimum of satisfaction of personal needs. Intrastaff relations have a higher emotional coloring, are more intimate and complicated in a place such as the Wisconsin Diagnostic Center than they are elsewhere, but the same basic principles operate. For that reason the section on administration can be read profitably by anyone with executive responsibilities, as can the entire article by all medical workers.

Hoxsey Hoax

Hallelujah and praise be to the Food and Drug Administration for its courageous, head-on attack against the so-called Hoxsey treatment for internal cancer. The FDA calls this high-priced "cancer cure" (red and black pills and liquids made up of everything from prickly ash bark to red clover) "a gross deception to the consumer" and a "worthless treatment." Straight talk such as this is almost certain to make a deep impression on the public.

Society Proceedings

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met May 10 at the Elks Club in Green Bay.

"Forty Ways to Reach Eighty Without Cancer" was the topic chosen by the guest speaker, Dr. R. J. Samp. Doctor Samp is affiliated with the department of surgery at the University of Wisconsin.

During the business session, approval was given to *Dr. Arthur J. McCarey's* motion to give a $500 gift to the A.M.A. education fund. It was also voted that a division of the Society be made, forming two sections, the Brown County Medical Society and the Door–Kewaunee County Medical Society.

Forty-three members were present at the meeting.

Calumet

Members of the Calumet County Medical Society met April 2 at Chilton. During the business session of the meeting, the staff officers for the Calumet County Memorial Hospital were elected. They are as follows: president, *Dr. N. J. Knauf;* vice-president, *Dr. E. W. Humke;* chief of the medical department, *Dr. K. R. Humke;* chief of surgery, *Dr. F. P. Larme;* and chief of obstetrics, *Dr. E. W. Humke.*

Fond du Lac

The Fond du Lac County Medical Society met April 26 at the Elks Club in Fond du Lac.

Dr. R. J. Samp, Madison, was the guest speaker. He discussed "Forty Ways to Reach Eighty Without Cancer."

At the business session, *Dr. Howard Mauthe,* Fond du Lac, was elected secretary of the society. He will fill the unexpired term of *Dr. D. A. Smith,* who will begin a residency in July.

Lafayette

Six members of the Lafayette County Medical Society attended a dinner meeting on April 17 at the Darlington Hotel in Darlington.

At the meeting the society voted to support local preschool physical examinations, including chest x-rays of school employees.

Manitowoc

The Manitowoc County Medical Society met April 26 at Wellhoefer's Sea Grill in Manitowoc. Twenty-two members of the society attended the meeting.

A general discussion was held concerning the topic of the guest speaker, Attorney John Nash of Manitowoc, who addressed the society on "The Doctor and Malpractice."

A report of the recent Fifth District Caucus meeting was given during the business session. A resolution concerning staff jurisdiction in hospitals and general practice representation on the Joint Accreditation Committee was drawn up for presentation at the recent State Medical Society convention.

The Public Welfare Committee of the Society reported on the new fee schedule which is approved and being printed.

The Medical Society of Milwaukee County

The Medical Society of Milwaukee County met April 12 at the Athletic Club, Milwaukee.

Guest speaker at the meeting was Dr. Milton Friedman, New York, associate professor of clinical medicine at New York University Medical School, and attending radiation therapist at Bellevue Hospital.

Doctor Friedman pointed out that supervoltage radiation treatment can save lives of some cancer victims, but it carries the risk of causing severe or even fatal x-ray injury to the patient. He described individual cases of cancer in which supervoltage treatment had apparently extended the life of the patients.

Outagamie

Ninety members of the Outagamie County Medical Society acted as hosts to the Sixth Councilor District meeting held April 19 at the Elks Club in Appleton.

The meeting was led by *Dr. G. W. Carlson,* Councilor for the Sixth District, and included a talk by *Dr. C. M. Kurtz,* professor of clinical medicine at the University of Wisconsin Medical School. He spoke on "Coronary Heart Disease."

Dr. A. R. Curreri, professor of surgery, and director of the cancer research hospital, University of Wisconsin, talked on "Management of Gastrointestinal Hemorrhage."

After a dinner for the members and their wives, Mr. Charles Crownhart and Mr. Earl Thayer, both of the State Medical Society, spoke to the group on "Recent Developments and Future Trends in Medical Economics."

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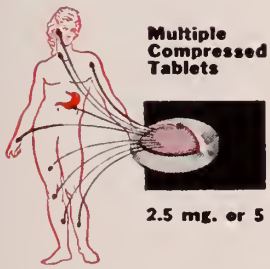

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References: 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

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Polk

The Polk County Medical Society met April 19 at the Dalles House in St. Croix Falls as guests of *Dr. M. E. Wegner.*

The guest speaker was Dr. Arnold Anderson, pediatrician from St. Louis Park, Minnesota, who spoke on "Urinary Tract Infections in Children." A round-table discussion about this subject followed the talk.

In a business session, a public clinic for first through third grades for polio immunization was approved.

Rock

The April meeting of the Rock County Medical Society was held at the Monterey Hotel, Janesville, on April 24.

Members of the society heard an address by *Dr. R. S. Cron,* professor of obstetrics and gynecology at Marquette University School of Medicine. Doctor Cron's topic was "Ovarian Carcinoma."

Rusk

On April 2, the Rusk County Medical Society was host to a group of neighboring physicians at a dinner held at St. Mary's Hospital in Ladysmith. Visiting doctors from Turtle Lake, Bloomer, Chippewa Falls, Rice Lake, Dallas, Cornell, and Chetek were guests at the meeting.

Dr. L. Sherman, Minneapolis surgeon, gave a lecture and showed movies.

Waukesha

Dr. F. D. Bernard, professor of surgery of the department of plastic surgery, University of Wisconsin Medical School, was the guest speaker at the Waukesha County Medical Society meeting held April 4 at the Merrill Hills Country Club in Waukesha. The group met with the Waukesha County Dental Society.

After Doctor Bernard's address regarding plastic surgery, an informal discussion was held. A social hour and dinner followed the scientific program.

Winnebago

The Winnebago County Medical Society met at the Athearn Hotel, Oshkosh, on May 10.

Drs. O. H. Stokke and *S. F. Morgan,* Milwaukee, presented the program.

Ninth Councilor District

Members of the Ninth Councilor District met April 10 at the Hotel Whiting in Stevens Point.

Dr. W. C. Sheehan was master of ceremonies, and *Dr. W. A. Gramowski* served as program chairman. The meeting was sponsored by the Pfizer Laboratories of Brooklyn, New York.

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1. Cronheim, G., and Toekes, I. M.: Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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Milwaukee Oto-Ophthalmic Society

On April 24 the Milwaukee Oto-Ophthalmic Society held its regular monthly meeting at the University Club in Milwaukee.

The program included a cocktail hour, dinner, and business session.

American Academy of General Practice

Wausau Chapter

The Wausau area chapter of the American Academy of General Practice held its spring dinner meeting at the Little Bavaria Inn, Wausau, April 12.

Dr. R. R. Richards, Eau Claire, state president of the group, was the guest speaker. He gave a report on the recent national meeting of the American Academy of General Practice held in Washington, District of Columbia.

Election of officers was conducted, and the following were elected for the ensuing term: president—*Dr. D. M. Green*, Wausau; vice-president—*Dr. William H. Knoedler*, Mosinee; and secretary—*Dr. T. C. Burr*, Wausau.

Thirteenth Councilor District

The Thirteenth Councilor District Meeting was held at the Langlade County Memorial Hospital on April 12. *Dr. W. P. Curran*, Antigo, councilor from the district, conducted the meeting.

Mr. Robert B. Murphy, Madison attorney, was the guest speaker. He discussed elements of law as they concern doctors as civilians and as practitioners of medicine. He also discussed interprofessional relationships between physicians and attorneys and the Interprofessional Code, joint publication of the State Medical Society and the Wisconsin Bar Association.

Section on Surgery

The annual meeting of the Section on Surgery of the State Medical Society was held in Milwaukee on May 2.

New officers were nominated and elected unanimously. They are: chairman, *Dr. T. J. Snodgrass* Janesville; secretary, *Dr. J. M. Sullivan*, Milwaukee; delegate, *Dr. G. N. Gillett*, Racine; and alternate, *Dr. J. D. Conway*, Milwaukee.

Section on Internal Medicine

New officers of the Section on Internal Medicine recently elected include *Dr. Warren Simmons* Rhinelander, chairman; *Dr. Robin N. Allin*, Madison, delegate, and *Dr. Louis Kurten*, Racine, alternate delegate.

Milwaukee Neuro-Psychiatric Society

The annual meeting of the Milwaukee Neuro-Psychiatric Society was held May 16 at the University Club in Milwaukee.

The guest speakers at the meeting were Leo Kanner, M. D., director of the children's psychiatric service at Johns Hopkins Hospital, Baltimore, Maryland, and Dr. K. K. Knapp, professor of pediatric neuro-psychiatry at the University of Wisconsin. They spoke on "Early Infantile Autism."

During the business session, election of officers was held. *Dr. I. J. Sarfatty*, Milwaukee, was named president, and *Dr. E. Madison Paine*, Green Bay, vice-president. The group elected *Dr. E. C. Schmidt* of Wauwatosa as secretary-treasurer, and *Drs. F. J. Millen*, Milwaukee, and *J. T. Petersik*, Winnebago, as councilors.

Milwaukee Academy of Medicine

Milwaukee Academy of Medicine members met on May 15 at the University Club in Milwaukee.

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, was the guest speaker. His topic was "Current Problems in Medical Education."

Wisconsin Urological Society

At the May 3 meeting of the Wisconsin Urological Society held in Milwaukee, *Dr. Earl Cummings*, Oshkosh, was named president of the group. *Dr. Albert Graham*, Neenah, was elected vice-president.

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1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia **25**:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

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Last year, 1955, Wisconsin Physicians Service paid claims totaling $3,224,197. Of this, nearly $2,498,000 was paid to participating physicians.

The above map shows the distribution of payments by counties. It should be remembered that the bulk of Wisconsin Physicians Service contracts are in group coverage, which is primarily in metropolitan areas. However, the relatively small dollar payment to Milwaukee County is explained by the fact that WPS sales are not conducted there. In addition, there is not a high proportion of the total coverage in individual, nongroup contracts, which may in part account for low payments to primarily rural counties.

It is interesting to note that about 20% of all physicians receiving payments last year received in excess of $2,000 each for services to Blue Shield subscribers. About 2,460 physicians rendered services to WPS subscribers during 1955.

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News Items and Personals

Footville Has New Physician

Dr. Roland Evenson, formerly of Marshfield, recently announced his intent to practice medicine in Footville.

Doctor Evenson is a graduate of Marquette University School of Medicine and has been practicing at Marshfield for the past three years. Footville has been without a practicing physician for the last two years.

Doctor Stang Joins La Crosse Clinic

Dr. Hartwick M. Stang recently joined the Gundersen Clinic in La Crosse, where he will serve as senior medical consultant.

He is a native of Eau Claire and was formerly associated with the Midelfart Clinic there.

Doctor Fowler Addresses Woman's Club

Dr. R. J. Fowler, Waterloo, recently addressed the Marshall Woman's Club in Marshall.

He described the symptoms and complications of the common childhood diseases, and urged that children be immunized for these diseases between the ages of three and six months so that they will be protected by the time their early natural immunity wears off.

Dr. W. E. Acheson Attends Medical Convention

Dr. and Mrs. *W. E. Acheson*, Valders, attended the recent convention of the Association of American Physicians and Surgeons. The meeting was held at Columbus, Ohio.

Dr. Sarah Rosekrans Named President of Pan-American Women's Medical Group

International honor was given *Dr. Sarah D. Rosekrans*, Neillsville, recently when she was selected as the next president of the Pan–American Medical Women's Alliance. Doctor Rosekrans will assume the office in two years.

She was elected to this position at the recent annual meeting of the Alliance which was held in Chile.

New Physician at Rice Lake Clinic

Dr. John R. McKenzie recently became associated with *Drs. O. E.* and *W. B. Rydell* at the Rice Lake Clinic.

Doctor McKenzie is a 1955 graduate of Marquette University School of Medicine and interned at Misericordia Hospital in Milwaukee. From 1945 through 1947 he served with the U. S. Marine Corps.

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Doctor Albrecht Speaks to Youth Group

Dr. James E. Albrecht, Jackson, addressed a "Christian Citizen Workshop" on April 15 in Watertown. His subject was "Beverage Alcohol and the Human Body."

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Kurtz Addresses P.T.A.

Dr. Chester Kurtz, Madison heart specialist, addressed the Washington School P.T.A. in Madison on April 11. Rheumatic fever was the subject of his talk.

Doctor Jackson Attends Meeting

Dr. Arnold S. Jackson, Madison, who is president of the U. S. section of the International College of Surgeons, was one of 33 surgeons from 14 states who participated in a program of the Southeastern regional meeting of the organization. The meeting was held April 30 at Chattanooga, Tennessee. Latest techniques in surgery and medicine were discussed.

Two Madison Physicians Attend Neurology Meeting

Drs. H. H. Reese and *E. P. Roemer,* both of Madison, recently attended the eighth annual meeting of the American Academy of Neurology. This meeting was held in St. Louis, and started April 23.

Doctor Marlow Speaks at Pharmacy Meeting

Dr. G. V. Marlow, Madison physician, addressed the Dane County Pharmaceutical Society on May 8 at a meeting held at the Madison Drug Company, Madison. Doctor Marlow chose as his topic "Proctological Procedures and Diagnosis."

Doctor Schindler Speaks in Beloit

Dr. J. A. Schindler, Monroe, recently gave a public address on mentally induced illnesses as the last in a series of talks sponsored by Beloit College. The address was given at the Eaton Chapel in Beloit.

Doctor Schindler, who is on the staff of the Monroe Clinic, is the author of the best seller, *How to Live 365 Days a Year.*

Doctor Hitz Named Officer of Ophthalmology Group

At the annual business meeting of the Chicago Ophthalmological Society, *Dr. J. B. Hitz* of Milwaukee was named councilor for the group. He will assume office in 1957.

Lectures Presented at U.W. Medical School

Dr. L. W. Kinsell of Oakland, California, presented a lecture at the University of Wisconsin Medical

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School on April 27. He spoke on "Observations Regarding the Role of Unsaturated Fat in Lipid Metabolism in Human Subjects." Doctor Kinsell is director of the Institute for Metabolic Research of the Highland–Alameda County Hospital in Oakland.

On May 3, a lecture sponsored by the Medical School was given by Dr. John L. Hampson, Johns Hopkins Hospital, Baltimore, Maryland. Doctor Hampson spoke at University Hospitals, and chose as his topic "Studies on the Psychopathology of Hermaphroditism."

Dr. J. V. Neel, chairman of the department of medical genetics at the University of Michigan, was guest speaker on May 10 at the Service Memorial Institutes Auditorium in Madison. Doctor Neel's subject was "Inherited Abnormalities of Human Hemoglobin."

Doctor Hellmuth Gives Talks

Dr. G. A. Hellmuth, director of the cardiovascular section at Marquette University School of Medicine and chief of cardiology at Milwaukee County General Hospital, presented a paper on "Treatment of Serious Arrhythmias in the Aged" at the annual meeting of the American Geriatrics Society held in Chicago on May 3. On May 17, he presented a paper on "Correlative Studies of the Electrocardiogram in Cor Pulmonale Following Thoracoplasty." This talk was given to the American College of Cardiology meeting held in Chicago.

On June 8, Doctor Hellmuth participated in a "Fireside Conference on Rheumatic Heart Disease" at the annual meeting of the American College of Chest Physicians in Chicago.

Doctor Cowan Participates in Meeting

Dr. I. I. Cowan, director, department of isotopes, Marquette University School of Medicine, participated in a symposium on radio colloids at the annual meeting of the Central Society of Nuclear Medicine held at the University of Chicago, May 6.

The title of his discussion was "Experiences with the Intracavity Use of Radiogold."

Milwaukee Doctor Speaks to Indiana Group

Dr. A. A. Pleyte, Milwaukee, addressed the La Porte, Indiana, County Tuberculosis Association on April 12. His subject was "Routine Hospital Admission Chest X-rays—Why?"

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OBITUARIES

Dr. Drexel Lowry Dawson, 67, died March 2 at his home after a long illness.

Doctor Dawson was born in 1889, and he received his medical degree from the University of Illinois in 1913. He interned at Cook County Hospital. He practiced medicine in Rice Lake for 28 years, and had been with the Veterans Administration in Madison and Eau Claire. At the time of his death, Doctor Dawson was authorizing medical officer for the VA in Milwaukee. He had served in both world wars and in India.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association, and a life member of the Association of Military Surgeons and the Reserve Officers' Association. He was a fellow of the American College of Surgeons.

Doctor Dawson is survived by his wife, Louise, of Milwaukee; a daughter, Mrs. Donald Mullen, of Wichita, Kansas; two sons, Dr. L. D. of Worthington, Minnesota, and Kenneth of Eau Claire.

Dr. James E. Heraty, 81 years of age, died April 23 at La Crosse.

Doctor Heraty was born in Fond du Lac in 1874. He entered Marquette University in 1894, and graduated from that school in 1901.

Before moving to Bloomington in 1904, he practiced medicine in Fond du Lac. After being discharged from military service in 1919, he moved to La Crosse.

He was a member of the La Crosse County Medical Society, a life member of the State Medical Society and member of its 50-year Club, and a member of the American Medical Association.

Survivors are one daughter, Mrs. Walter Wiffler, La Crosse; two sons, James Jr., Minneapolis, and Capt. J. P. of California; four grandchildren; one brother; and one sister.

Dr. George W. John, who had practiced medicine in Beloit since 1929, died at a Beloit hospital on May 9. He was 60 years of age.

In addition to his private practice at Beloit, Doctor John had served as plant physician for Beloit Iron Works since 1929.

He was born on May 19, 1895, in St. James, Missouri. He attended the University of Missouri and received his medical degree at Northwestern University in 1927. He served his internship at Buffalo, New York.

Doctor John started his medical practice at Long Beach, California, and next moved to Ironwood, Michigan, where he conducted private practice and was physician for a mining firm. He later located at Beloit.

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He was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his wife, two sisters, and four brothers.

Dr. Otto Erich Toenhart, 52, died on March 31 at his home.

He was born in 1904 in Milwaukee. He received bachelor of science, master of science, and doctor of philosophy degrees in chemistry from the University of Wisconsin. He did graduate work in chemistry in Munich, Germany, and received his medical degree from the Harvard University Medical School in 1934.

Doctor Toenhart practiced medicine at Sheboygan before locating in Milwaukee in 1943.

He was a member of the American Medical Association, the State Medical Society of Wisconsin, and the Medical Society of Milwaukee County.

Surviving him are his wife, Bessie, of Milwaukee; three brothers, Walter, Milwaukee, Frank, Nemahbin Lake, and Charles, Mayville; and a sister, Mrs. Flora Kraft, of Milwaukee.

Dr. Gustav Schmitt of Milwaukee died April 7 at a Milwaukee hospital after a long illness. He was 93 years of age.

After graduating from medical school in 1898, Doctor Schmitt practiced medicine in Chicago, and later moved to Milwaukee, where he was located until his death.

Doctor Schmitt was in practice in Milwaukee with his brother Phillip until 1943, when most of the practice was turned over to his brother so that Doctor Gustav might devote more time to conducting a crusade against tuberculosis. In 1903 he had been named president of a three-man commission to make recommendations on a state tuberculosis institution. This led to the establishment of Wisconsin's first sanatorium at Wales.

There are no immediate survivors.

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Dr. William D. McNary, 85 years of age, died at his home in Milwaukee on April 15 after a long illness.

He was graduated from Rush Medical College of Chicago, and had practiced medicine in Milwaukee for 63 years.

He is survived by his wife, Bessie; a brother, Dr. J. Foster McNary, of Milwaukee; and a sister, Mrs. Edward C. Clark, of Miami Beach, Florida.

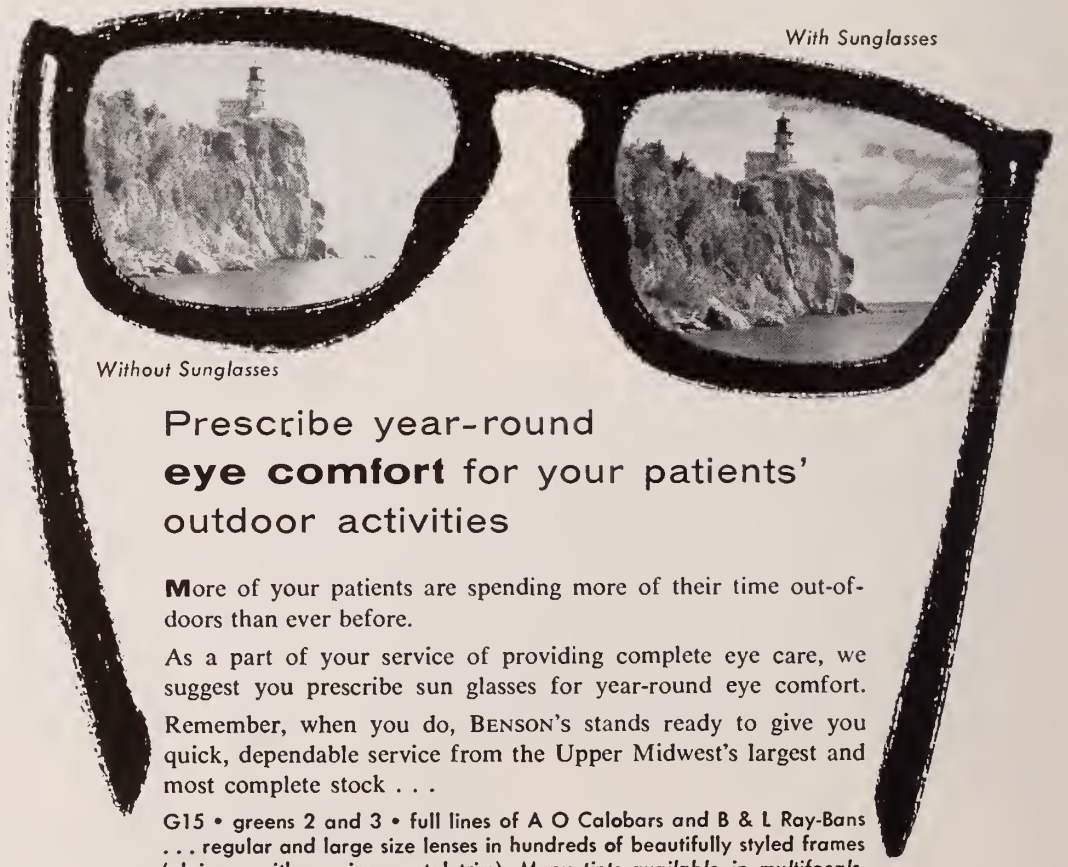
Dr. Edward W. Quick, 86 years of age, died at a Milwaukee hospital on April 10 following a short illness.

Born in 1870 in Cordova, Illinois, Doctor Quick received his medical degree from Rush Medical School in 1902. He served his internship and residency at Cook County Hospital in Chicago before beginning his practice in Appleton. He later moved to Green Bay, and in 1913 began practicing in Milwaukee.

Doctor Quick's special interest was in surgery. He was a fellow of the American College of Surgeons and the Academy of Medicine, and a member of the American Society of Industrial Physicians and Surgeons.

He was a life member of the State Medical Society of Wisconsin and a member of the Medical Society of Milwaukee County and the American Medical Association.

Doctor Quick is survived by his wife, Georgia, of Milwaukee and one daughter, Mrs. Louise Boches, Waukegan, Illinois.



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Practice of Allergy. By Warren T. Vaughan, M. D. Revised by J. Harvey Black, M. D. Third Edition. St. Louis, The C. V. Mosby Company, 1954. Price $21.00.

This is a well-written, authoritative text on allergy. The author is an experienced allergist, and he has done an excellent job of presenting the material. Of particular value is the section on Pulmonary Physiology, which should be read by all interested in the field.

The volume itself is largely a reference book, of value to the allergist rather than to one casually interested in the field.

The reviewer feels that eliminating some of the discussions on older theories in the field of allergy might cut the size and the cost of the book.—S. B. C.

Pomp and Pestilence; Infectious Disease, Its Origins and Conquest. By Ronald Hare, M. D., Professor of Bacteriology in the University of London at St. Thomas's Hospital Medical School. New York, The Philosophical Library, Inc, 1955. Price $5.75.

This is an important book. In it Professor Hare presents for the general reader a panorama of "infectious disease, its origins and conquest," and brings him face to face with problems attending the "virtual elimination of infectious disease as a cause of death and disablement."

For the professionally interested person there is some very satisfying reading: a well-based conjecture as to the time and place at which prehistoric man acquired his endemic diseases; their journey with him throughout the world; the history of some of the great epidemic diseases—smallpox, plague, typhus, cholera, dysentery, influenza; the associated fall of armies, nations, and civilizations (the Hittites, the Roman Empire, the Hurons, the Grand Armée); the struggle between the Hippocratic and the modern view of the source, nature, treatment, and control of infectious disease; maritime quarantine (Ragusa) and the first public health laws in England in the fourteenth century; the development of sanitary engineering, of artificial active immunization, of specific chemotherapy and antibiotics; and the persistence of a state of flux between man and his parasites. And in the end, the possibility of the grim alternatives suggested at the beginning.

In addition to the inherent excellence of his book, *Pomp and Pestilence*, the author gives a section (Notes and References) furnishing a bibliography for each chapter. The reviewer has read the book with distinct profit and enjoyment and recommends it to students and practitioners of medicine.—F.E.H.

When Minds Go Wrong. By John Maurice Grimes, M. D. New York, The Devin-Adair Company, 1954. Price $3.50.

The principal thesis of this book is that the mentally ill in our hospitals have been subjected to shameful and brutal treatment. It is unfortunate that so important an issue should be observed in the maze of vituperation, personal attack, and ludicrous theorizing which constitutes the bulk of this small volume.

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The "cause" of all mental illness is casually expounded in the first 14 pages. The author then comments concerning his hypothesis, ". . . it will probably be quite a period of time before psychiatrists in general frankly accept it, for such a simple explanation of the functional disorders makes their psychiatric knowledge and skill seem less important, and it weakens their monopolistic hold on their lucrative mental patient practice." Review of the author's explanations of the cause of mental illness leads this reviewer to agree that it will be quite a period indeed before such naïve formulations gain general acceptance.

The author comments about psychiatry, ". . . is quite often called a racket. It is not a racket. In order to survive, a racket must be both aggressive and modern. Psychiatry is neither."

The bulk of the volume, then, is a kind of autobiographical sketch of the writer's experiences on the staffs of eight psychiatric hospitals. He repeatedly found incompetence, political control, brutality, cowardice, and indifference. He found superintendents who were more interested in his politics than in his competence. He discovered that movement from a state hospital is often denied patients because workers are needed within the hospital. He found gross neglect and shameful care the rule rather than the exception. He tasted the vile food, smelled the fetid odors, and witnessed the strait jackets and cuffs—all synonymous with the words "care for the mentally ill."

The author's suggestions for modification of the state hospital system are not without merit. A number of these suggestions are currently embodied in the growing movements today effecting change in our mental hospital system. These include replacement of attendants with trained nurses or practical nurses or specially trained aides, seeking means for eliminating political control of the hospital system, and emphasis upon social living rather than incarceration for the mentally ill. It is paradoxical that this book serves to attack personally, by name, several of the very persons who have been most instrumental in working toward the proposals now offered by the author. How are we to call to this important service our most skilled workers if the very books which spell out the need give hint that abuse and insult will be a major part of the reward? —M.H.M.

Clinical Aspects of the Autonomic Nervous System. By L. A. Gillilan, Ph.D., M. D., Associate Professor of Anatomy, Graduate School of Medicine, University of Pennsylvania. Boston and Toronto, Little, Brown and Company, 1954. Price $6.50.

This volume, consisting of 266 pages, can be summarized by the closing paragraph of the introduction: "The present monograph is a summary of the isolated facts available from various and scattered sources. While no new material is recorded, the assembled facts have been correlated and arranged in such a way that the clinician will be able to use them in his practice. It is intended to furnish an anatomic and physiologic background for his clinical work. The clinical applications in the second portion should suggest further avenues for thought and application of the subject to diagnostic work."

The first six chapters of the book deal with the anatomy of the autonomic nervous system; the remaining six chapters treat of the innervation of the various visceral systems.

Interspersion of references throughout the text makes for awkward reading in a few places. For example, on page 11, "Either in or very close to the frontal area (area 8) and occipital (areas 18 and 19) eye fields (Figures 1 and 2), pupillary changes can be elicited by stimulation of the cortex (Vogt and Vogt, 1907; Hines, 1940; Smith, 1943; Crosby *et al.*, 1952).

On page 153 one reads, "Interrupting the vagus trunk above the cardiac level on one side permits the heart to function without marked inconvenience to the individual, but bilateral interruption is incompatible with life." On pages 170–171 occurs, "Serious damage to both main vagal trunks by cutting, destructive lesions, or by pressure leads to marked respiratory embarrassment of the patient in addition to cardiac irregularities."

The bibliography of 434 references is a particularly desirable aspect of the work. The book is useful for the purpose which the author intended.—F.D.G.

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Fluoroscopy in Diagnostic Roentgenology. By Otto Deutschberger, M. D., Assistant Clinical Professor of Radiology, New York Medical College; Roentgenologist in Charge, Bird S. Coler Memorial Hospital, N. Y.; and Associate Visiting Roentgenologist, Metropolitan Hospital, N. Y. Philadelphia and London, W. B. Saunders Company, 1955.

This book covers the subject of fluoroscopy in considerable detail. After initial chapters concerning the development of fluoroscopy, equipment, and physical factors and hazards of the procedure, the remainder of the book is devoted to a discussion of the clinical aspects of fluoroscopy of the various structures and regions of the body. Techniques of examination are detailed and the findings in a wide variety of conditions discussed. Numerous illustrations (reproductions of roentgenograms and line drawings) are used to clarify the textual matter.

Actually, there is much in the book that is not fluoroscopy. For many diseases there is a description of the finer roentgenologic changes, changes which can hardly be recognized or differentiated by conventional fluoroscopy. In most instances the author indicates how much reliance can be placed upon the fluoroscopic findings in such conditions, but this material does add to the bulk of the text.

For those who wish to learn something about the techniques of fluoroscopy, what to look for, and how to evaluate it, the book should prove useful.—L.W.P.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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LOCUM TENENS wanted for a general practice during month of July or August. Very attractive offer. Address replies to H. Y. Fredrick, M. D., Box 253, Westfield, Wis.

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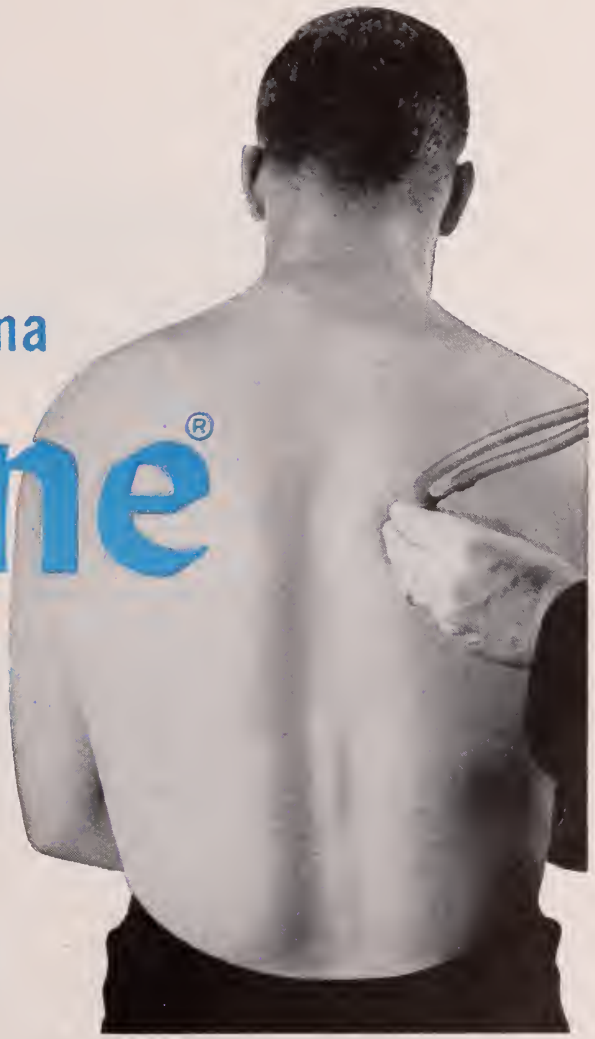

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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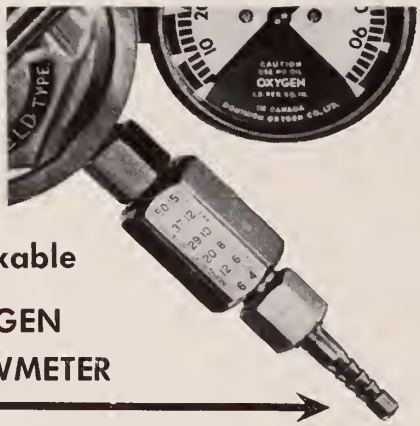

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INDEX TO ADVERTISERS

	Page
Ames Company, Inc.	683
Ayerst Laboratories	609
Barr X-Ray Company	664
Benson Optical Company	676
Breon, George A., & Company	606
Brown and Williamson Tobacco Corp.	610
Burroughs Wellcome & Co., Inc.	608
Ciba Pharmaceutical Products	670
Coca-Cola Company	597
Cook County Graduate School of Medicine	602
Corn Products Company	601
Davies, Rose & Co., Ltd.	675
Doerflinger Artificial Limb Co.	675
Endocrine Laboratories	673
Foot-so-Port Shoe Company	666
General Electric	604
Gyne–Cytology Laboratory	672
Haug Drug Company	669
Hotel Schroeder	609
House of Bidwell	664
Hurley X-Ray Company	669
Keeley Institute	677
Kennedy–Mansfield	596
Lakeside Laboratories	609, 665, 679
Lederle Laboratories	634, 635, 666
Lilly, Eli and Company	616
Linde Air Products	682
Mallard, Incorporated	679
Mallatt Pharmacy	596
Mather Pharmacy	596
Medical Protective Company	669
Milwaukee Sanitarium Foundation, Inc.	684
New York Polyclinic	678
Orthopedic Appliance Company	672
Parke, Davis and Company	594, 595
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	605, 681
Physicians and Hospitals Supply Company	602
Physicians Casualty Association	662
Pogue, Mary, School, Inc.	672
Professional Business Service	655
Rennebohm's	596
Riker Laboratories, Inc.	663
Rogers Memorial Sanitarium	684
Sacred Heart Sanitarium	674
St. Croixdale Sanitarium	597
Schering Corporation	599, opposite 610, 614, 615
Schieffelin and Company	602
Searle, G. D. and Company	649
Sharp & Dohme	661
Shorewood Hospital Sanitarium	671
Smith, Kline & French Laboratories	598, 612
Squibb, E. R., & Sons, Div. of Mathieson Chemical Corp.	600, 611
Time Insurance Company	653
Upjohn	673
Wallace Laboratories	650
Wine Advisory Board	613
Winthrop Laboratories, Inc.	607
Wisconsin Neurological Foundation	666
Wyeth	603, 667

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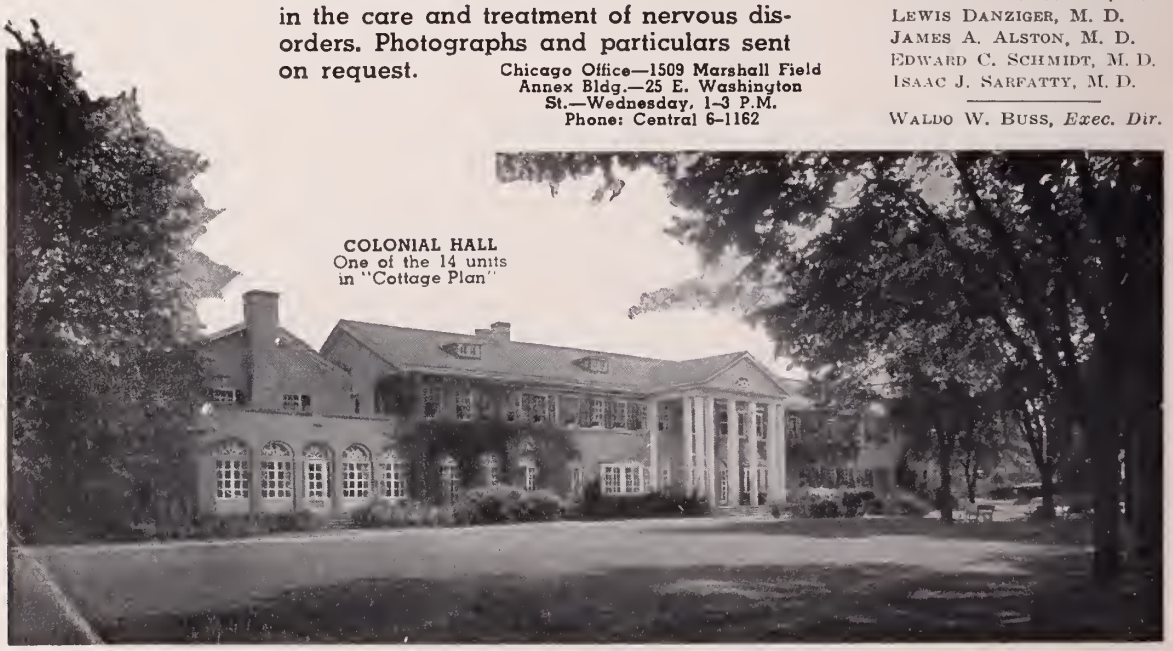

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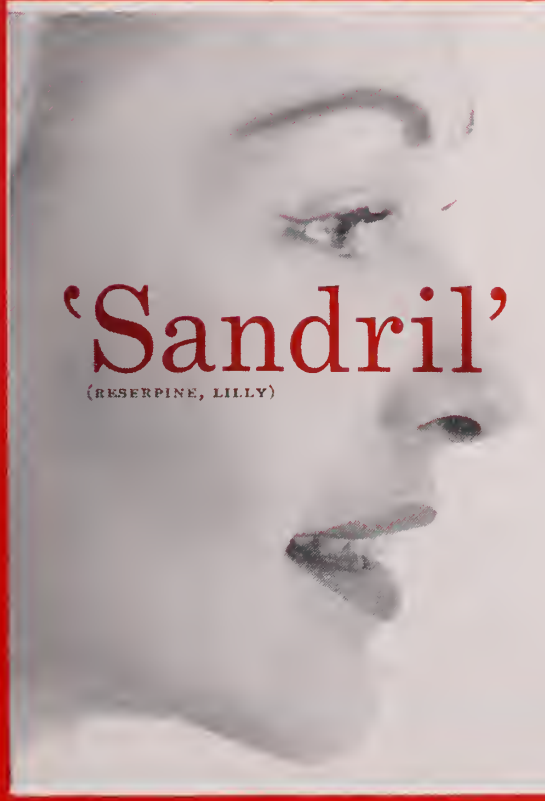

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1. Davidson, D. T., Jr.; Lombroso, C., & Markham, C. H.: *New England J. Med.* 253:173, 1955.
2. Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955.

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Volume 55
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TABLE OF CONTENTS

Scientific Articles

	Page
The Prognosis in Dissecting Aneurysms of the Aorta; Therapeutic Suggestion, by D. Joe Freeman, M. D.	709
Pancreatic Cyst, Internal Drainage by the Roux-en-Y Technique, by Marvin E. Sattler, M. D.	722
The Problem of Acute Anuria, by D. M. Willson, M. D., W. M. Kearns, M. D., and D. G. Santer, M. D.	726
Cardiac Arrest, by D. W. Barrow, M. D., and R. I. Doberneck	732
Clinicopathologic Conference	738
Comments on Treatment	742
A Quarter Century of Water Supply Safety	744

Miscellany

	Page
Society Proceedings	750
News Items and Personals	760
Third and Twelfth Districts News	762
Society Records	764
Facts About Wisconsin Physicians Service	766
Obituaries	768
The Journal Bookshelf	779
Physicians' Exchange	780
Index to Advertisers	782

Editorials

	Page
A Library for Medicine	746
A Gratifying Response	746
The President's Page	748

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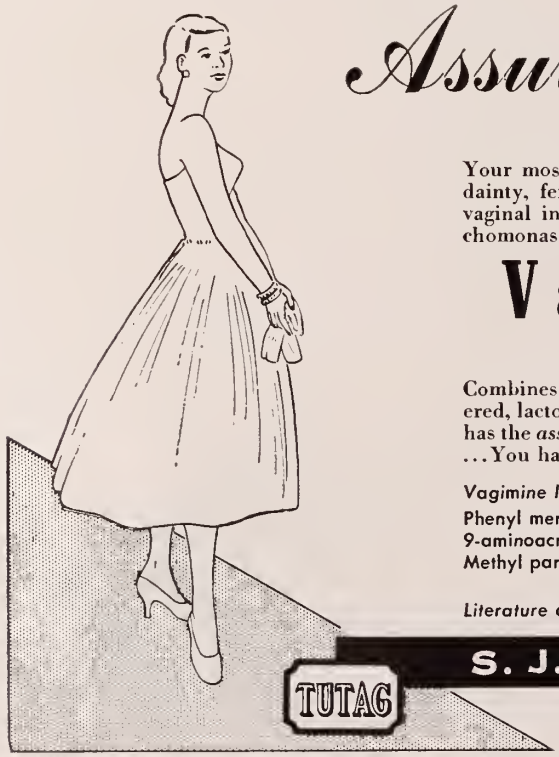

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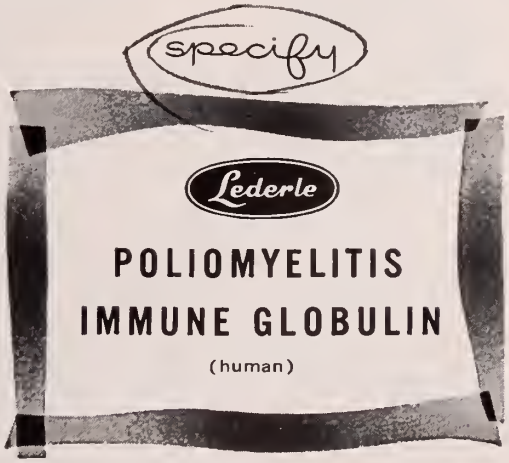

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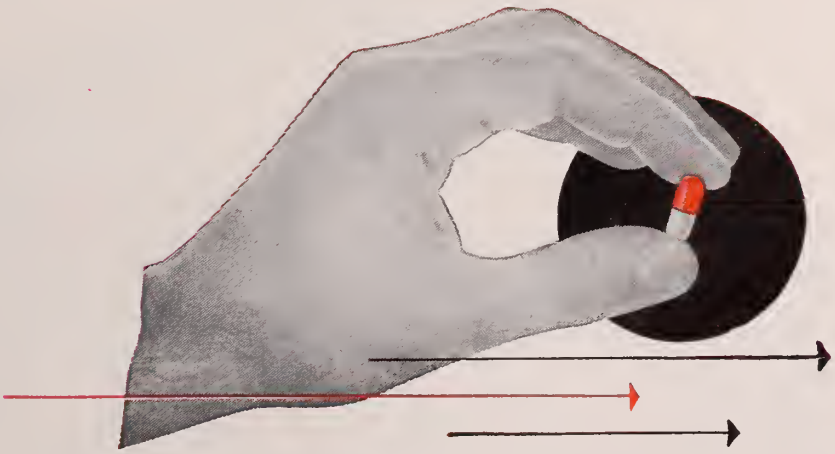

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1. Wallick, H., Harris, D.A., Reagan, M.A., Ruger, M., and Woodruff, H.B., *Antibiotics Annual*, 1955-1956, New York, Medical Encyclopedia, Inc., 1956, pg. 909.
2. Frost, B.M., Valiant, M.E., McClelland, L., Solotorovsky, M., and Cuckler, A.C., *Antibiotics Annual*, 1955-1956, pg. 918.
3. Verwey, W.F., Miller, A.K., and West, M.K., *Antibiotics Annual*, 1955-1956, pg. 924.
4. Kempe, C.H., *Calif. Med.*, **84**:242, April 1956.
5. Simon, H.J., McCune, R.M., Dineen, P.A.P., Rogers, D.E., *Antib. Med.*, **2**:205, April 1956.
6. Lubash, G., Van Der Meulen, J., Berntsen, C., Jr., Tompsett, R., *Antib. Med.*, **2**:233, April 1956.
7. Lin, K.-E., Coriell, L.L., *Antib. Med.*, **2**:268, April 1956.
8. Limson, B.M., Romansky, N.J., *Antib. Med.*, **2**:277, April 1956.
9. Morton, R.F., Prigot, A., Maynard, A. de L., *Antib. Med.*, **2**:282, April 1956.
10. Nichols, R.L., Finland, M., *Antib. Med.*, **2**:241, April 1956.
11. Mullins, J.F., Wilson, C.J., *Antib. Med.*, **2**:201, April 1956.
12. David, N.A., Burgner, P.R., *Antib. Med.*, **2**:219, April 1956.
13. Marton, W.J., Heilman, F.R., Nichols, D.R., Wellman, W.E., and Geraci, J.E., *Antib. Med.*, **2**:258, April 1956.
14. Milberg, M.B., Schwartz, R.D., Silverstein, J.N., *Antib. Med.*, **2**:286, April 1956.

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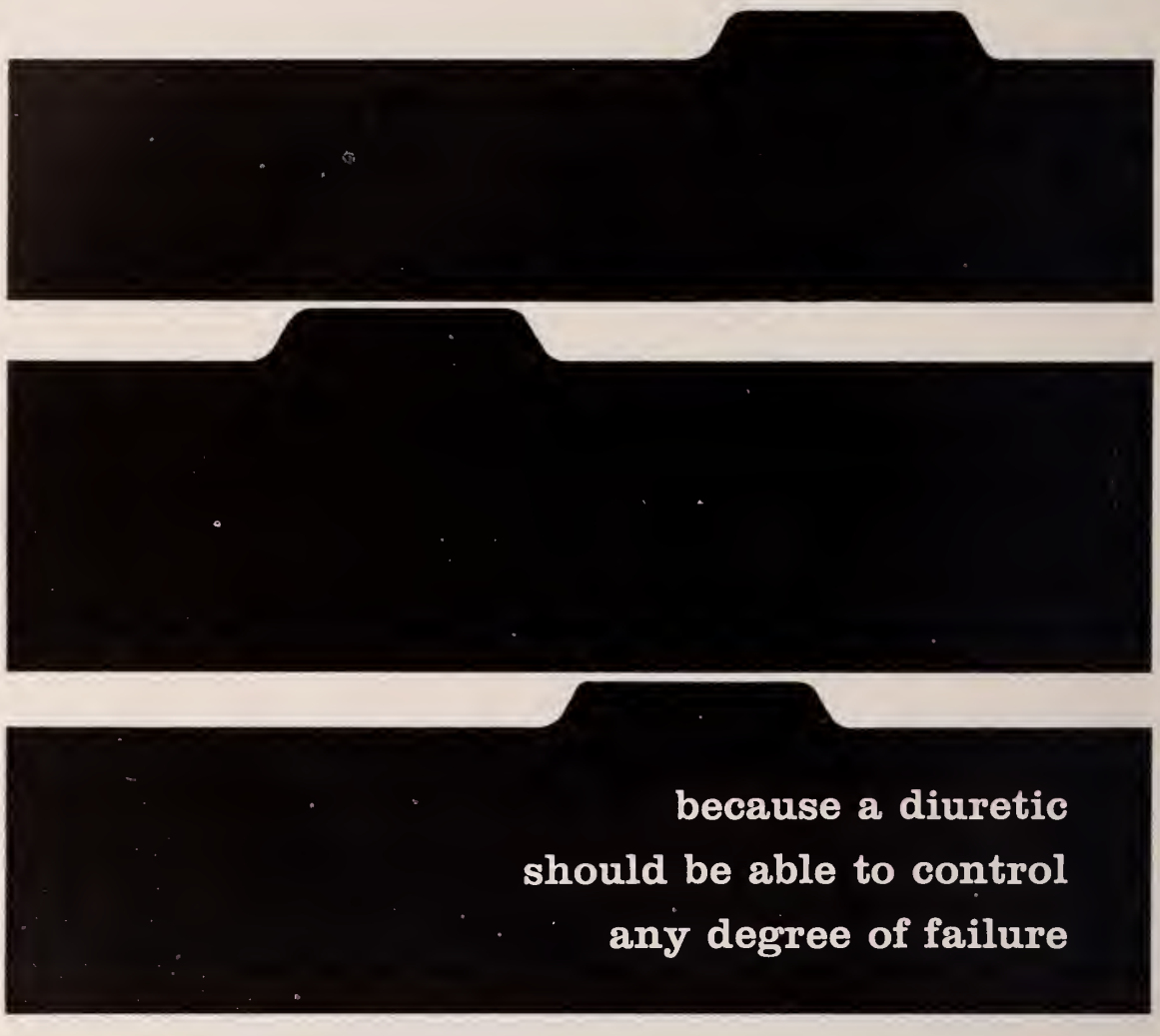

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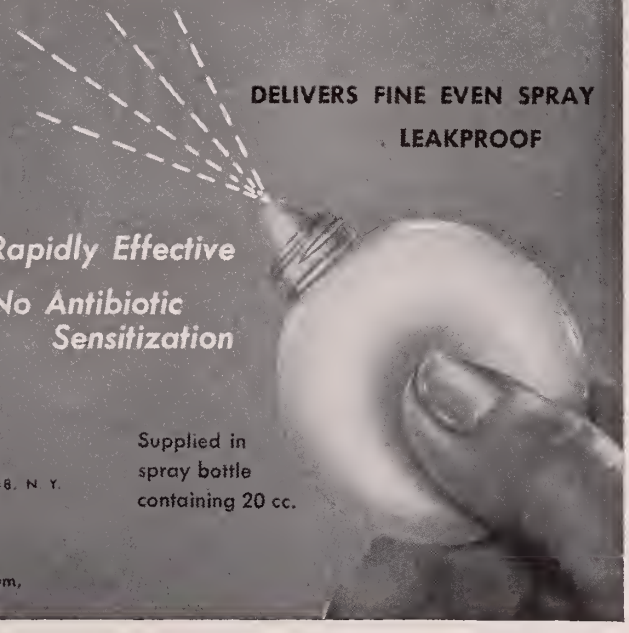

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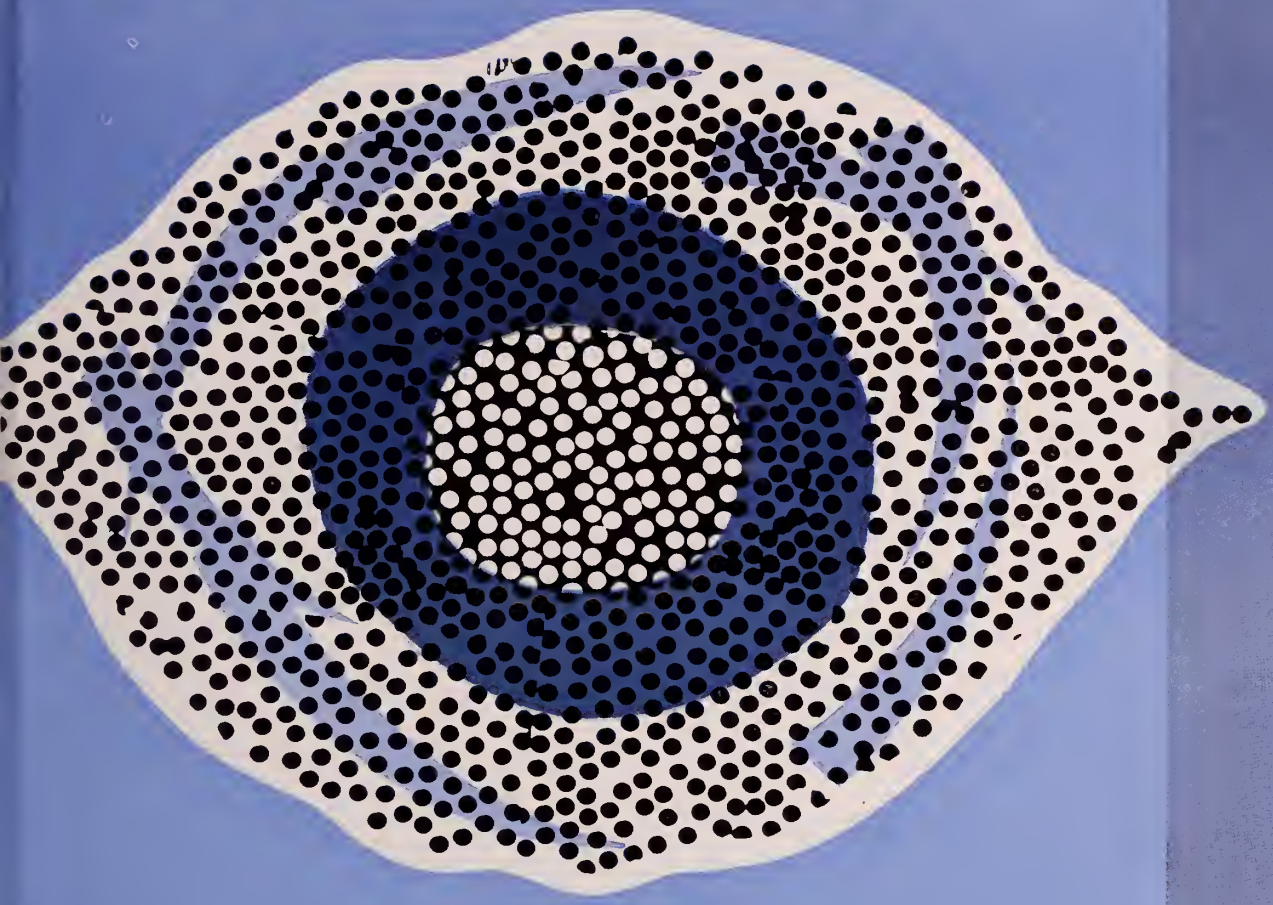

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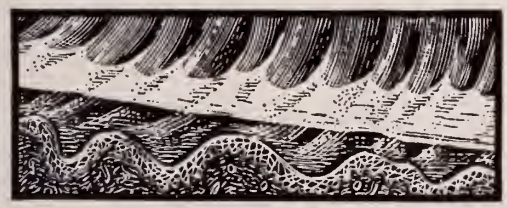

VAGISEC liquid penetrates to trichomonads buried among the vaginal rugae and imbedded in mucus and desquamated cells.

Hidden trichomonads. Trichomonads do not exist in the vaginal secretion alone. They are vigorously motile and burrow deeply into the surface of the vaginal mucosa where cellular debris and mucus cover them. VAGISEC liquid lowers surface tension, penetrates the cellular debris and dissolves mucoid material[1,2] that lines the vaginal wall and lies buried among the rugae. It reaches and explodes hidden as well as surface trichomonads.

Unique overpowering action. VAGISEC liquid combines a chelating agent and two surface-acting agents that act in balanced blend to weaken the trichomonad's cell membrane, to remove its waxes and lipids, and to denature its proteins. The parasite imbibes water, swells up and explodes. *No other agent or combination of agents kills the trichomonad in this specific fashion, or with this speed.*

Trichomonads explode within 15 seconds. "Motion pictures taken through a phase-contrast microscope at 24 frames per second show that individual trichomonads are destroyed within 10 to 14 seconds after contact . . ." with solution of VAGISEC liquid.[3]

The Davis technique.† The remarkable speed and uniquely effective action of this trichomonacide are the result of the intensive research of its originators, Dr. Carl Henry Davis, well-known gynecologist and author, and C. G. Grand, research physiologist, who introduced the agent as "Carlendacide" and had it clinically tested by more than 150 physicians, including over 100 leaders in obstetrics and gynecology.[2,3] In this extensive evaluation, better than ". . . 90 per cent of apparent cures have been obtained. . . ."[2] For "the small percentage of women who have an involvement of cervical, vestibular or urethral glands, other treatments will be required."[3]

Office treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Office treatments are an integral part of the Davis technique.

Home treatment. Prescribe both VAGISEC liquid and jelly. Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual cycles, but omitted on office treatment days. Douching contraindicated in pregnancy.

Summary. VAGISEC liquid penetrates to hidden trichomonads and explodes them in 15 seconds. VAGISEC jelly and liquid are nontoxic and non-irritating, leave no messy discharge or staining. VAGISEC liquid and jelly have been clinically tested and proved a remarkably fast-acting, effective treatment for vaginal trichomoniasis.

Active ingredients: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

1. Davis, C. H.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954.
2. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.
3. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955.

†Pat. App. for

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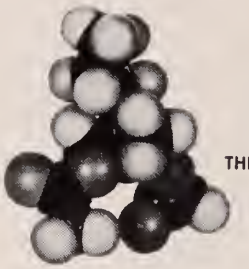

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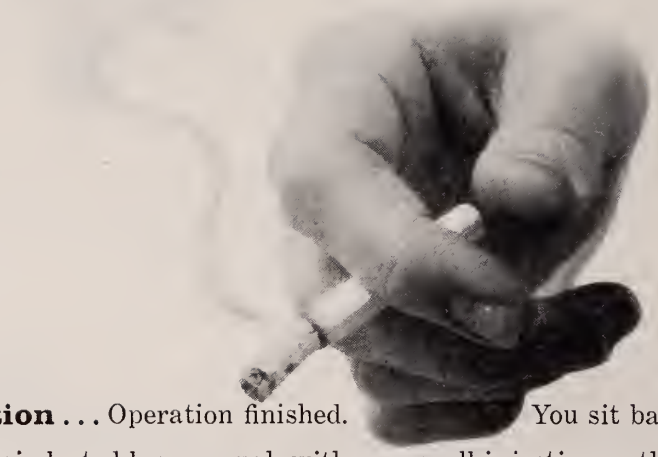

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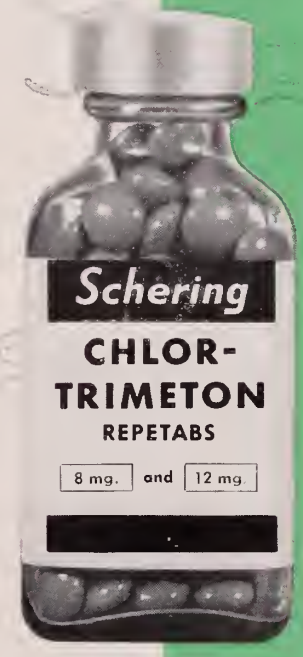

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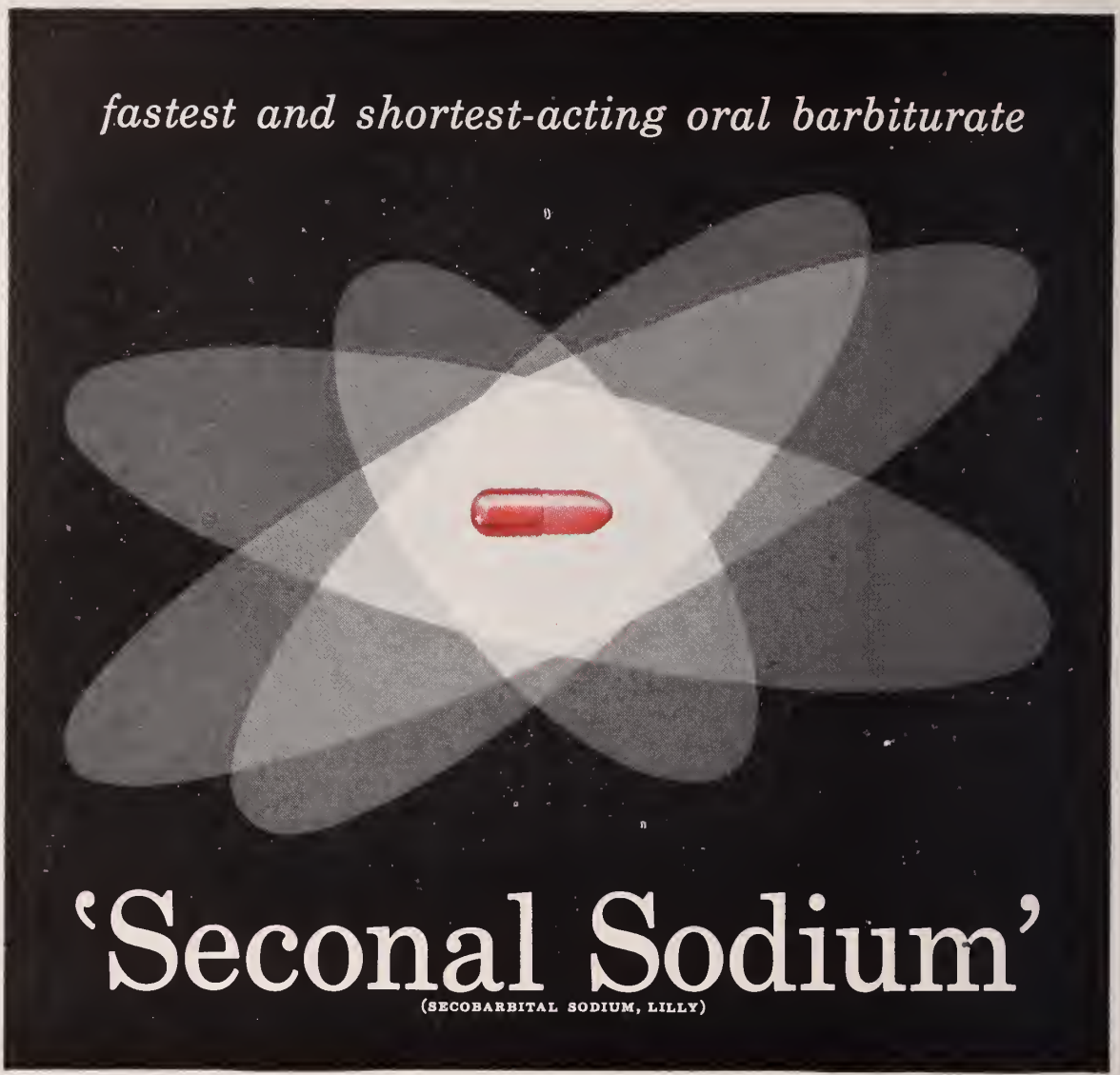

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THE WISCONSIN MEDICAL JOURNAL

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The Prognosis in Dissecting Aneurysms of the Aorta Therapeutic Suggestion

By D. JOE FREEMAN, M. D.*
Madison

SINCE the cases reported in Shennan's monograph[1] in 1934, the ante-mortem diagnosis of dissecting aneurysm of the aorta has been made with increasing frequency. The condition is uncommon, but not rare; its incidence is estimated at from 0.2 to 0.4% of all autopsied cases.[2-5] In the last 15 years at the Cincinnati General Hospital, the incidence has been about 0.22% of autopsied cases.

The pathogenesis of dissecting aneurysms has been one of nature's mysteries since it was first described by Morgagni[6] and later named by Laennec.[7] McCloskey and Chu[2] summarize what is perhaps the most widely accepted idea as follows: "A weakened condition of the medial coat (caused by unknown factors, possibly a metabolic defect)[8] is associated with cystic medionecrosis, rupture of the vasa vasorum and resultant intramural hematoma. Intra-aortic pressure is exerted on this hematoma and spreads it along lines of least resistance. As the hemorrhagic extravasation continues, further dissection occurs and, ultimately, the intima is destroyed and communication with the aortic lumen occurs. This facilitates further dissection due to the added effect of (direct) intra-aortic pressure." Subsequently, thrombi formation, dilatation, and progressive weakening of the dilated wall lead to the usual end point of sudden rupture and death. At least one intimal tear is almost invariably present. Etheridge *et al.*[3] state that in 10 to 20% of all cases a second intimal tear develops. The production of this second intimal tear, or re-entrance, may lead to, as Osler[9] describes it, "An illustration of the most remarkable reparative process seen in the human body, the formation of a healed dissecting aneurysm" or, as it is commonly called, a "double-barrelled" aorta. Other cases may become "healed" by thrombosis, organization, and fibrosis of the intramural hematoma.

It is commonly accepted that the most frequent "healed" cases are those in which re-entry has resulted in numerous variations of a "double-barrelled" aorta. The only statistical support for this opinion is apparently a review of Shennan's figures by Jones and Langley in 1946.[10] These authors state that only 4% of all patients live longer than five weeks if no re-entry occurs, while if it does, about 72% survive five weeks. However, David *et al.*[11] believe the fact that "so many patients succumb to the initial attack in spite of such a communication indicates that its occurrence is not the overall determining factor in length of survival after onset."

The purpose of this study is to determine the factor or factors affecting the prognosis in this usually fatal disease, with the thought of possibly improving therapy.

MATERIAL AND METHODS

The material has been obtained from clinical and necropsy data on 23 cases at Cincinnati General Hospital from 1938 to 1953 and from over 400 cases described in the American and English literature since 1943. Of the latter group, only 161 cases[12] were detailed enough to be included. Among the

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23 Cincinnati General Hospital necropsy cases, dissections were found as incidental conditions at necropsy in three.[13] Of the remaining 20,[14] three[15] were excluded because of incomplete data. Hence, a total of 178 cases have been included in this report.

The method of analysis of these cases can be seen on study of the tables. The mean survival time is usually three to four days; the majority of patients die within the first week. Mote and Carr[16] report 39 of 60 coroner cases who did not survive for longer than 24 hours after the onset of the dissection. This is a high incidence of early deaths compared to that reported in other series.[1,2,4,12] In order to determine any factor or factors influencing survival from the initial insult, our patients were first separated into two general groups: those surviving less than one week and those surviving a week or more (table 1). The effect of time on the sequence of pathological events is most difficult to determine in dissecting aneurysms. An attempt is made to resolve this difficulty in part by further breaking down these groups as indicated in tables 2, 3a, 3b, and 3c. In this series of 178 cases, 43% of the patients survived the first week; this incidence is undoubtedly about 15 to 25% too high. The reason for this is that cases with a longer survival, and particularly so-called "healed" dissecting aneurysms, are presented in the literature with much more detailed clinical and necropsy data than are the more acute ones. This is unfortunate, but the nature of this study makes accurate data of prime importance.

TABLE 1

	Survival less than one week	One week or more	Total
NUMBER OF CASES	101 (57%)	77 (43%)	178
Onset Age (Decades)			
2nd	1 (1%)	0	1 (+%)
3rd	3 (3%)	3 (4%)	6 (3%)
4th	11 (11%)	8 (10%)	19 (11%)
5th	26 (26%)	19 (25%)	45 (25%)
6th	28 (28%)	23 (30%)	51 (29%)
7th	25 (25%)	21 (27%)	46 (26%)
8th	7 (7%)	3 (4%)	10 (6%)
SEX (males)	78 (78%)	55 (71%)	133 (75%)
Miscellaneous Factors			
Congenital anomalies:			
Cardiovascular	6 (6%)	3 (4%)	9 (5%)
Other	4 (4%)	4 (5%)	8 (4%)
Syphilitic aortitis	4 (4%)	1 (1%)	5 (2%)
Congestive failure prior to onset	6 (6%)	1 (1%)	7 (4%)
Pregnancy or early puerperium	4 (4%)	1 (1%)	5 (2%)
Aortic stenosis	3 (3%)	3 (4%)	6 (3%)
Uremia prior to onset	5 (5%)	2 (3%)	7 (4%)
Other	15 (15%)	16 (21%)	31 (17%)
Hypertension			
Prior to Onset:			
Cases used	48	39	87
No evidence	7 (15%)	11 (28%)	18 (21%)
>200/130	9 (19%)	3 (8%)	12 (14%)
140/90–200/130	12 (25%)	9 (23%)	21 (24%)
Historical (confirmed at necropsy)	20 (42%)	16 (41%)	36 (41%)
Necropsy Evidence Only	23	Not determinable	
Undetermined	30	38	68
Atherosclerosis			
None	10 (14%)	4 (8%)	14 (11%)
Minimal	21 (28%)	15 (28%)	36 (28%)
Moderate	26 (35%)	24 (45%)	50 (39%)
Marked	17 (23%)	10 (19%)	27 (21%)
Undetermined	27	24	51
Re-entrance			
At Distal End:			
Into aorta	6 (6%)	13 (17%)	19 (11%)
Into common iliacs	1 (1%)	10 (13%)	11 (7%)
Not At Distal End:			
Into aorta	0	1 (1%)	1 (+%)
Into aortic branches	2 (2%)	1 (1%)	3 (2%)
None	92 (92%)	52 (68%)	144 (81%)

ANALYSIS OF DATA

What are the factors that influence the immediate and distant* prognosis in dissecting aneurysm of the aorta?

Age

About 86% of the 178 patients were over 40 years of age and about 60% over 50. The onset age by decades is not significantly different in the group surviving and the group not surviving one week (table 1). The average onset age in patients surviving two weeks with and without re-entry is not significantly different regardless of whether or not they survived six months (table 3a, page 712). Hence it does not appear that age has any marked effect on the prognosis in this disease.

Sex

The ratio of males to females is usually reported as about 2–3:1.[1-5] In this series, the ratio was about 3:1 in both groups surviving and not surviving one week (table 1). Among the 39 patients not surviving 24 hours and the 35 patients surviving more than one month, males predominated at a rate of about 4:1 and 2:1 respectively. This suggests that females are not only less likely to have the disease, but also more likely to become "healed" cases if they do. However, the ratio was 3:1 in the 22 cases surviving six months (table 3a). Thus, sex does not appear to significantly affect the prognosis.

*Arbitrarily, "distant survival" designates survival for longer than two weeks after the initial onset of dissection.

Race

Sixty-six per cent of the patients were Caucasians. Most of the remaining were Negroes; 3 Orientals were afflicted. In 39 of the 178 cases, race was not noted. Due to the fact that many of these cases were found in teaching institutions which derived a disproportionate number of their patients from the Negro population, the significance of these figures is questionable.

Miscellaneous Factors

Congenital defects, particularly cardiovascular, are commonly associated with dissecting aneurysms.[12c,17] Among the 178 patients in this study, 9 (5%) had congenital cardiovascular anomalies, four of which were bicuspid aortic valves (table 1). An additional 4% had other types of congenital anomalies, including arachnodactylia (1), strabismus (3), hernia, etc. It would appear, therefore, that congenital cardiovascular defects predispose to dissection. However, the number of cases is too small to ascertain the effect on longevity in this disease (table 3c, page 713).

The same conclusion must be reached in attempting to evaluate any of the other miscellaneous factors (table 3a). Perhaps pregnancy and previous cardiovascular disease exert a deleterious effect, but this cannot be stated with certainty (table 1). The presence of syphilitic aortitis in 2% of the cases is high (table 1); however, as the tendency to report such a double lesion would be greater, this increase is probably more apparent than real.

Hypertension Prior to Onset

The selection of patients was strictly limited to those who historically either did or did not have prior hypertension; in each case, the historical data were confirmed by necropsy evidence. Unfortunately, only 87 cases were complete enough to be included, about one-half in each group (48 and 39 respectively—table 1). Four categories were designated: one, those with no historical or necropsy evidence of prior hypertension; two, those with severe blood pressure elevations (more than 200/130); three, those with moderate elevations (140/90 to 200/130); and four, those with historical evidence (confirmed at necropsy) in whom the magnitude of readings was not recorded.

Seventy-nine per cent of these 87 cases had hypertension prior to the onset of dissection. Of the 48 cases not surviving one week, 19% (9) had a history of severe hypertension; while 15% (7) had no evidence of prior hypertension. On the other hand, of the 39 cases surviving one week, only 8% (3) had prior severe hypertension, while 28% (11) had no evidence of prior hypertension (table 1). In the two remaining groups, no significant differences are noted. Hypertension, and particularly severe hypertension, not only predisposes to dissections (as is commonly accepted), but apparently adversely affects the prognosis once dissection has occurred.

Interestingly, only 8% of the entire series (159 patients) had no evidence of ever having hypertension. It was not determined in 19 patients because they were in shock and/or died before any record was made of the blood pressure. Perhaps, then, dissecting aneurysm of the aorta may of itself produce hypertension due to primary or reflex (via the carotid and/or aortic bodies) arteriolar spasm and/or its effect on renal blood flow.

Atherosclerosis

The role of atherosclerosis in the production of dissecting aneurysms has been a much-debated one and is adequately treated elsewhere.[2,4,8,17] The dissection is associated with, and apparently caused by, a primary disease of the media (cystic medial necrosis), not of the intima. Even in the presence of atherosclerosis, the site of primary intimal rupture is usually in an intact, relatively normal intima and not in an ulcerated plaque.

The relationship of atheroma to longevity in this disease is even more difficult to evaluate. Ninety-two per cent of the patients who survived the initial insult even for relatively short periods had atheromatous changes not only in the true aorta, but also in the dissected channel. Consequently, it is impossible to determine whether or not these changes were present prior to the onset in many cases. However, to compare extremes, if one assumes that no atheroma of significance will develop in one month's time, only 7 (about 37%) of the 19 patients with severe atheromatous changes surviving less than one month died in less than 24 hours, while of the 12 patients with no atherosclerosis surviving less than one month, practically the same percentage (33%) failed to survive for 24 hours. Hence, it would appear that

TABLE 2*

	Days Survived						Months Survived				Total Cases
	<1	1–2	2–4	4–7	7–14	14–30	1–6	6–24	24–48	>48	
NUMBER OF CASES	(39)	(24)	(18)	(20)	(28)	(14)	(13)	(9)	(6)	(7)	(178)
Extent of Dissection											
Localized:											21% (37)
ascending	13	4	6	15	11	7	15	0	0	0	9
arch	5	0	0	0	4	0	0	0	0	0	2
descending	0	0	6	5	4	7	8	0	0	0	3
abdominal	3	4	11	10	7	7	8	22	0	14	7
Moderately Extensive:											27% (48)
ascending—arch	10	13	0	5	4	0	0	0	33	0	6
arch—descending	0	0	0	0	7	7	8	0	0	0	2
descending—abdominal	5	4	0	10	7	7	8	0	0	0	5
ascending—descending	8	8	0	5	4	0	0	0	0	0	4
ascending and/or arch—abdominal above or at superior mesenteric artery	10	8	22	0	7	14	15	11	17	0	10
Extensive:											52% (93)
ascending aorta and/or arch—abdominal below superior mesenteric artery	46	58	56	50	50	50	38	67	50	86	
Primary Intimal Rupture											
ascending	65	67	39	50	36	21	15	45	33	57	47
arch	20	17	33	25	36	36	62	22	50	14	29
descending	0	4	6	5	11	14	15	0	0	0	6
abdominal	3	4	0	5	7	0	8	22	0	29	6
none	13	8	22	15	11	29	0	11	17	0	13
Re-entrance											
At Distal End:											
Into aorta and/or common iliacs	5	13	11	0	7	14	23	67	67	86	17% (30)
Not At Distal End:											
Into aorta and/or its branches	5	0	0	0	7	0	0	0	0	0	2% (4)
No Re-entrance	90	87	89	100	86	86	77	33	33	14	81% (144)

*All figures not in parenthesis represent a percentage of cases within each of the ten survival groups indicated. All figures in parenthesis represent the actual number of cases, not percentage.

TABLE 3a.—*Relationship of Distant Prognosis to Clinical Features Present Prior to Onset*

	Survival Period in Months			
	Without Re-entry		With Re-entry	
	½–6	>6	½–6	>6
NUMBER OF CASES	22	6	5	16
Average Onset Age	52.5	57.2	51.6	50 7
Sex (Males/Females)	6/5	2/1	4/1	3/1
Severe Hypertension	2	0	0	1
Moderate Hypertension	4	0	0	1
No Evidence of Hypertension	4	2	0	4
Congestive Failure	1	0	0	0
Cerebrovascular Accident	2	0	0	1
Uremia	1	0	0	0
Pregnancy or Early Puerperium	0	0	0	0

atherosclerosis has no marked effect on the immediate survival in dissecting aneurysms of the aorta. Atherosclerosis does affect the extent of the dissection; this feature is discussed later in the section on "extent and location of dissection."

Spontaneous Re-entry

Table 1 demonstrates a striking difference with regard to re-entry between patients in the group surviving less than one week and those in the group surviving a week or more. Thirty per cent of those surviving one week had a spontaneous re-entry of the dissected channel at its distal extent, while this was present in only 7% of those not surviving one week. The number of cases with re-entry not at the distal extent was only 4; 2 of these patients survived one week. Although one might expect that this circumstance would improve the prognosis, the number of cases is too small to evaluate. Hence, all further references to "re-entry" refer to distal re-entry only. With regard to re-entry, too, the factor of time is important and poses the difficult question, "Did re-entry occur because the patients survived, or did they survive because of re-entry?" In considering the immediate survival the question is impossible to answer. Table 2 demonstrates, however, that re-entry can occur within a few hours to a few days in some cases.

The effect of re-entry on the distant prognosis in this disease is more significant. If one assumes that re-entry, if it is to occur, will develop within two weeks following the onset of dissection, table 2 and figure 1 (page 714) suggest an improved prognosis with this occurrence. To demonstrate this

more clearly, table 4 illustrates the comparatively rapid decline in the survival rate of the 28 patients surviving more than two weeks with no re-entry as compared to the more gradual decrease in the 21 patients surviving more than two weeks with re-entry. Of those who survived the initial dissection by at least two weeks, the mean duration of survival is about six months in the absence of re-entry; it is almost four times that in its presence. Again based on the assumption that natural re-entry, if it is to occur, usually does so by the end of the second week, the data summarized in tables 3a, 3b, and 3c support the hypothesis that re-entry is the factor most improving the distant prognosis in cases of dissecting aneurysms of the aorta. Although it cannot be proved, it is probably true that it improves the immediate prognosis as well.

TABLE 3b.—*Relationship of Distant Prognosis to Clinical Features Present After Onset*

	Survival Period in Months			
	Without Re-entry		With Re-entry	
	½–6	>6	½–6	>6
NUMBER OF CASES	22	6	5	16
Severe Hypertension	8	1	2	7
Moderate Hypertension	8*	2	2*	2
No Evidence of Hypertension	1*	2	1*	4
Shock Only	2	0	0	0
Not Stated	3	1	0	3
Congestive Failure	3	2	5	2
Uremia Related	1	2	0	1
Uremia Not Related	1	0	0	1
Cerebrovascular Accident Related	0	0	0	1
Cerebrovascular Accident Not Related	0	0	1	2
Myocardial Infarction Related	2	0	0	1
Cause of Death Related:				
External Rupture	12	1	2	4
Congestive Failure	2	1	1	2
Fresh Dissection**	2	2	1	2
Myocardial Infarction	2	0	0	0
Uremia	1	0	0	0
Esophageal Erosion	0	1	0	0
Cause of Death Not Related:				
Cerebrovascular Accident (hemorrhage)	0	0	1	2
Peptic Ulcer	1	0	0	0
Pulmonary Embolism	1	0	0	0
Uremia	1	0	0	1
Sepsis***	0	0	0	1
Cause of Death Undetermined	1	1	0	4

*Readings in some of these cases may actually have been at shock levels in view of the possibility of hypertension. Arbitrarily, the patient was not designated as in shock unless the systolic level was less than 100 mm. of mercury and other signs of shock were evident.

**Includes cases with seepage externally without apparent rupture, as well as shock.

***One patient with acute bacterial vegetations on the aortic valve and also at the intimal rupture sites; his death was not considered to be due to dissection *per se*.

Extent and Location of Dissection

Again, the factor of time makes evaluation difficult. About 56% of the 18 patients with localized dissections in the abdominal or descending aorta survived the first week, and 28% the first month. Of the 34 patients with dissections localized in the ascending aorta or with extension from the ascending aorta no farther than the descending portion, these percentages were 29% and 12% re-

TABLE 3c.—*Relationship of Distant Prognosis to Anatomical Features*

	Survival Period in Months			
	Without Re-entry		With Re-entry	
	½–6	>6	½–6	>6
NUMBER OF CASES	22	6	5	16
Extensive dissections	9	2	3	13
Localized ascending or arch	3	0	0	0
Localized beyond arch	4	2*	0	1*
Other	6	2	2	2
1° rupture ascending or arch	15	1	3	15
1° rupture elsewhere	3	3	2	1
No intimal rupture	4	2	0	0
Involvement of major aortic branches:**				
Coronary	2/6	0/1	0/1	1/7
Of arch	6/6	1/1	3/3	11/12
Renal	6/10	4/4	1/3	7/11
None	1/15	0/4	1/3	0/10
Atherosclerosis (of aorta):				
Marked	3	3	1	3
None or minimal	5	0	1	3
Miscellaneous factors:				
Congenital cardiovascular anomalies	0	1	0	0
Syphilitic aortitis	0	0	1	0
Aortic stenosis	1	1	0	1

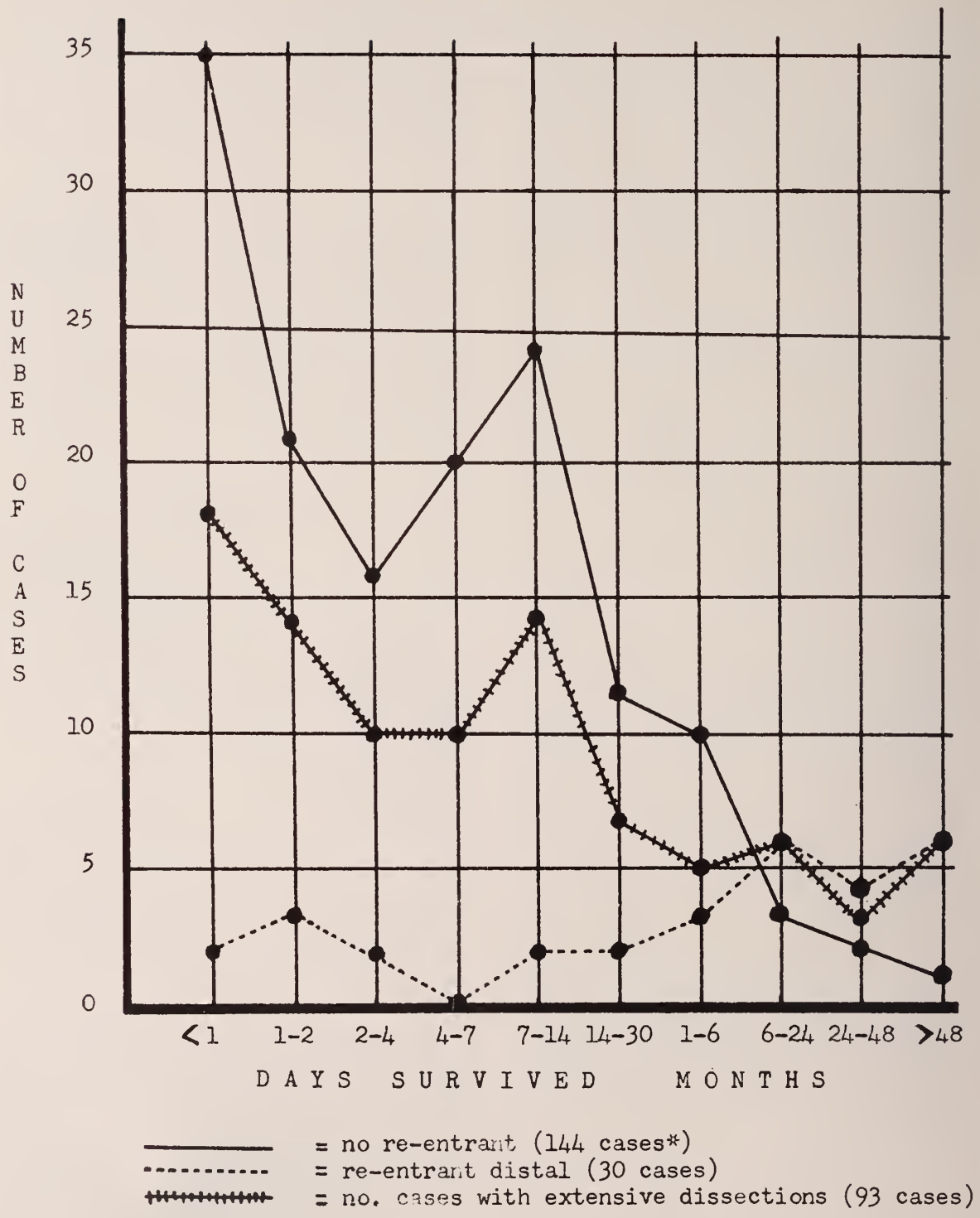
*Cases having the dissection localized in the abdominal aorta.

**Denominator indicates number of cases in which data were available. To be included, of course, cases had to demonstrate dissection of the area concerned. This does not mean to imply a necessary functional impairment but only that the dissection extended circumferentially about the branch and/or into it for a respectable distance, and/or that luminal encroachment was manifest.

TABLE 4.—*Comparison of Survival Rates**

	Months Survived				
	½–1	1–6	6–24	24–48	>48
Without Re-entry	100% (28)	57% (16)	21% (6)	11% (3)	4% (1)
With Re-entry	100% (21)	90% (19)	76% (16)	48% (10)	29% (6)

*The numbers in parenthesis designate the total number of patients surviving for the periods indicated.



* 4 cases not having distal re-entry not included.

Fig. 1—Relationship of survival to re-entry and extensive dissection.

spectively; in the entire series (178 cases), they were 43% and 20%. Hence, it would appear that the farther from the heart the dissection originates, the better the prognosis.

About 50% of the entire series and of each of the groups in table 2 (except those surviving for 1 to 24 months and for more than four years) had extensive dissections, that is, dissections extending from the ascending aorta and/or arch into the abdominal aorta below the origin of the superior mesenteric artery. This suggests that extensive dissection, if it is to occur, usually does so within the first 24 to 48 hours. Perhaps the extent of initial dissection is more related to other factors, rather than to time.

What influence do hypertension and atherosclerosis have on the extent of dissection? Again, to compare extremes, 75% of the 12 patients known to have severe hypertension prior to onset had extensive dissections; on the other hand, such dissections occurred in only 45% of the 18 patients having no evidence of prior hypertension. It seems, therefore, that severe hypertension predisposes to extensive dissection, while the absence of hypertension has no significant effect. Thirty per cent of the 27 patients with severe aortic atherosclerosis had extensive dissections. In the 50 patients with no or minimal atherosclerosis, about 50% had this development. Consequently, severe atherosclerosis apparently tends to localize the dissection, while minimal or no atheromatous change appears to have no significant effect. In cases with extensive dissections, medionecrosis can usually be found at either extreme of the lesion, even though survival has been for only a few hours. It is doubtful that such a pathological process could develop so rapidly; it must have been present in varying degrees prior to onset. In the absence of hypertension or atherosclerosis, then, perhaps the chief factor determining the limits of dissection is the amount of existent medionecrosis.

Curiously, 75% of the 30 cases with distal re-entrance had extensive dissections, whereas such dissections were present in only 47% of the cases without re-entrance of any kind. As the presence of distal re-entry improves the prognosis, it would appear that extensive dissection does so as well. But it has already been shown that severe hypertension probably adversely affects the prognosis and, at the same time, is more likely to produce extensive dissections. These data are contradictory. Could the fact that only 1 of the 9 patients with prior severe hypertension and failure to survive one week had a distal re-entrance be related? Perhaps the severity of the process, coupled with preexisting cardiovascular damage, did not allow sufficient time for re-entry to occur before death supervened. The fact that 6 of these 9 patients failed to survive the initial 24 hours supports this thesis. Although more common in the presence of severe hypertension, perhaps extensive dissection offers a more favorable outlook by providing a sort of buffer effect against extreme pressure build-ups in the dissected channel. Such an action would decrease the likelihood of external rupture (the usual cause of death) and allow more time for re-entry of the dissected channel to occur. Figure 1 illustrates that this explanation may be justified. Note how the lines indicating distal re-entry and extensive dissection gradually parallel one another. In 13 of the 16 patients with distal re-entry and survival for longer than six months, there was associated extensive dissection, while such dissection occurred in only 2 of the 6 patients without re-entry surviving that period (table 3c, page 713). Furthermore, in 2 of these 6 patients, the dissection was localized in the abdominal aorta, a circumstance already suggested as improving the prognosis. Although the unknown factor of time defies dogmatism, these data suggest that extensive dissection improves the distant prognosis if the dissection originates close to the heart.

Initial Intimal Rupture

Figure 2 demonstrates the effect of the absence or presence of initial (or primary) intimal rupture, and of its location, on survival. If more than one rupture occurs, the initial one is almost always the proximal one. Initial intimal rupture in the ascending aorta has an adverse effect on the immediate prognosis as compared to rupture in other sites. The distant survival is not markedly different. In the absence of intimal rupture, the immediate prognosis is improved; however, of the 23 patients with this circumstance, only 2 survived one month and one survived two years. These were usually localized dissections and were usually not in the ascending aorta, a circumstance this study indicates is

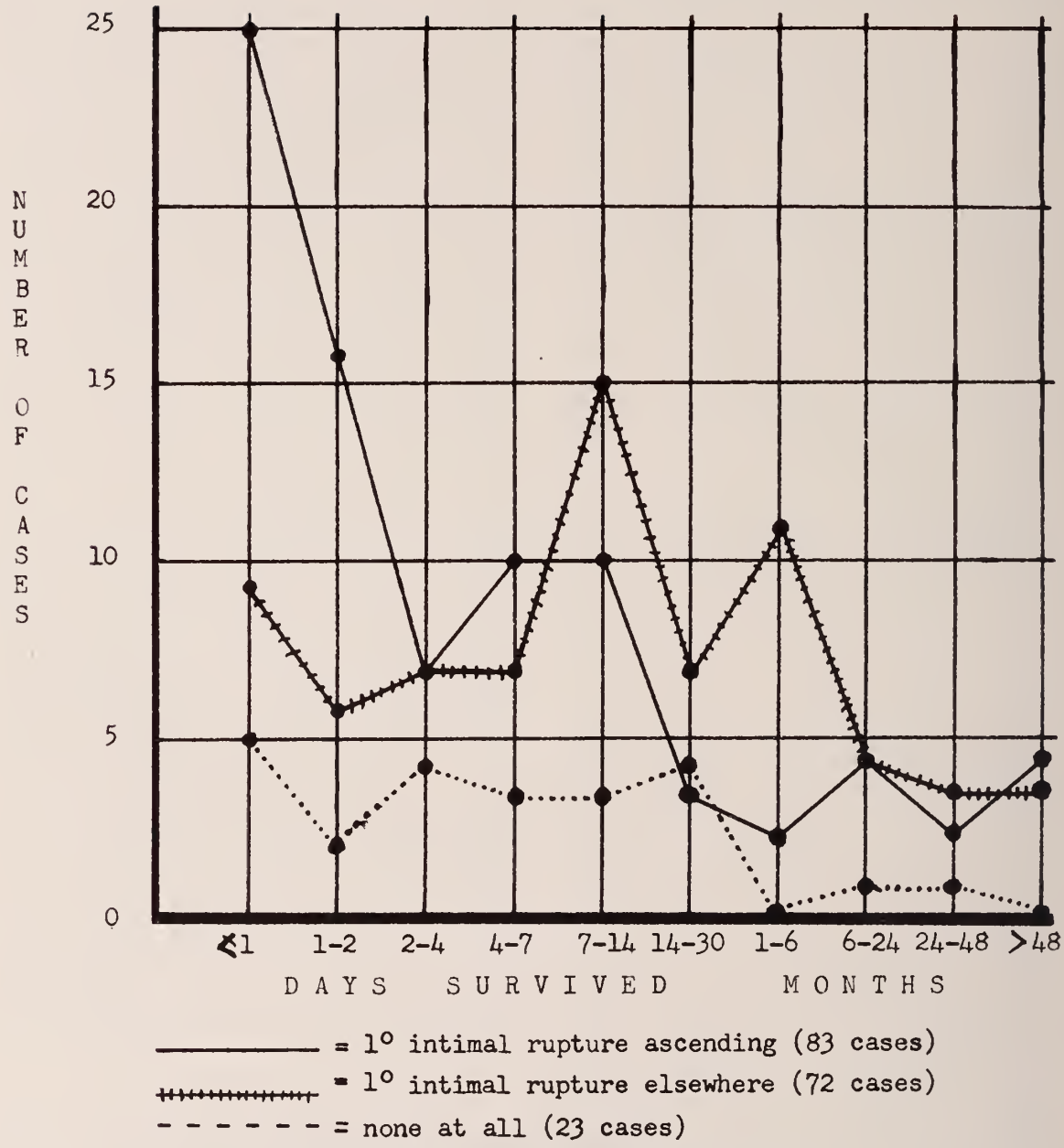


Fig. 2—Relationship of survival to initial intimal rupture.

associated with an improved immediate prognosis. Whether or not the absence of rupture and, thus, of direct intra-aortic pressure is a factor cannot be proved. In this regard, 2 of the 3 cases in which dissection was found incidentally at necropsy should be mentioned. In each, there was only a small hematoma; one was with intimal rupture, one without. In one of the 3 cases, only cystic medionecrosis was present, without aneurysm or hematoma.

The data presented in table 3c, page 713, are of interest. Fifteen of the 22 patients without re-entry and not surviving six months had primary intimal rupture in the ascending aorta or arch. On the other hand, 15 of the 16 patients surviving six months with re-entry had primary rupture in these areas. In addition, 6 of the 28 cases without re-entry had no intimal rupture at all. Thus if primary rupture occurs, it would appear that extensive dissections and re-entry are

more likely to occur. This is probably due to the added effect of direct intra-aortic pressure.

Involvement of Major Aortic Branches

This, unfortunately, has been almost impossible to evaluate adequately. Most of the literature cases mention branch involvement only when it has been associated with clinically manifest impairment during life or do not mention it at all. Documented negation of aortic branch involvement is unusual, as is mention of the degree of existing involvement. Table 3c summarizes the available data on the 49 patients surviving two weeks. The numerator indicates the number of cases in which the dissection extended circumferentially around the branch and/or into it, and/or produced grossly detectable luminal encroachment; it is not necessarily meant to imply functional impairment. The denominator indicates the number of cases in which data were available and in which dissection of the area concerned had occurred. It would appear that branch involvement occurs in almost all cases but that it has no marked effect on the prognosis in the average patient.

Summary—Influencing Factors

In summary, it is most difficult to evaluate the various interrelated factors affecting the immediate and distant prognosis in dissecting aneurysm of the aorta. The significance of time makes positive definition doubly difficult. Because re-entry is apparently the factor most influencing distant survival after onset and is probably greatly dependent on time; *i.e.*, the duration of survival, for its development, table 3 represents an attempt to uncover other important factors that might be concealed in the above analysis by a comparison of 28 cases without re-entry and 21 cases with re-entry. It is based on the assumption that re-entry, if it is to occur, usually does so within two weeks. All patients surviving two weeks are included, and the interrelated clinical and anatomical features bearing on the prognosis are listed.

Review of table 3a does not suggest significant differences in the two groups other than the failure of 22 of the 28 cases without re-entry to survive six months while 16 of the 21 cases with re-entry survived longer than that period. The adverse effect of hypertension is again apparent. Of note, perhaps, is the survival for more than six months of 2 patients with moderate or severe hypertension prior to onset in the group with re-entry, while none of the 6 patients with moderate or severe hypertension without re-entry survived for over six months. The 1 patient with prior severe hypertension and re-entry was also the one having a cerebrovascular accident prior to the onset of the dissection. The occurrence rate of the other factors is so low that evaluation is questionable and does not seem significant.

The various features present after onset (table 3b) are not strikingly different in the two groups. Fatal myocardial infarction was related to the dissection in 2 patients without re-entry; related myocardial infarction occurred in only 1 patient with re-entry and was not fatal. Three patients without re-entry had related uremia; this was present in only 1 patient with re-entry. The 1 patient having a related intracranial accident survived the episode. Probably of significance is an unrelated cause of death in only 3 of the 26 patients without re-entry, while 5 of the 17 patients with re-entry died of other causes. The cause of death was undetermined in 2 patients without re-entry and in 4 with re-entry. The anatomical features compared in Table 3c have already been discussed.

In conclusion, the chief factor improving distant survival in dissecting aneurysm of the aorta is the spontaneous re-entry of the dissected channel at or near its distal extent. Other factors apparently improving the distant prognosis include: 1. the absence of hypertension, particularly severe hypertension; 2. localized dissection away from the heart (the farther away, the better the prognosis); 3. intimal rupture away from the heart (the farther away, the better); 4. extensive dissection, particularly if it originates close to the heart; 5. the absence of major involvement of important aortic branches (particularly the coronary arteries); and, possibly, the absence of congenital cardiovascular defects, previous noncongenital cardiovascular disease, and pregnancy or early puerperium. These factors are probably also important in the immediate survival from the onset of dissection as well.

Age and sex seem to have no marked effect on survival. The relationship of race, atherosclerosis, and various other factors could not be satisfactorily evaluated. Al-

though atherosclerosis tends to localize dissections, it does not seem to have any marked effect on immediate survival. The appearance of atheromatous change in the dissected channel is quite common. In some cases, it may be even more severe that that in the true aorta.

A hypertensive effect of dissection itself has been suggested, as has the effect of severe hypertension on the extent of dissection.

It is suggested that in the absence of severe hypertension or atherosclerosis, the extent of the dissection is related to the existent medionecrosis more than to any other factor.

The buffering effect of an extensively dissected channel has been offered as a possible explanation for the improved outlook apparently associated with this circumstance.

DISCUSSION OF THERAPEUTIC SUGGESTION

Interest in dissecting aneurysm of the aorta has largely been centered on its challenge to one's diagnostic acumen. Only three,[18,19,20] or perhaps six, attempts at surgical intervention have been made. Three probable dissecting aneurysms associated with coarctation (one of the right subclavian artery) have been treated by resection; however, the pathological reports do not definitely establish the nature of the process.[21-23] In two of the attempts at surgical intervention, cellophane wrapping of the aorta was employed; the other attempt will be discussed below. The data presented above demonstrate that spontaneous re-entry of the dissected channel at its distal extent is nature's best method of healing dissecting aneurysms of the aorta. Perhaps the best therapist is one who knows how most effectively to help nature in the management of her problems. How else, then, could one better help nature in this task (which she so uncommonly accomplishes) than by surgically producing a re-entry? Only one such attempt has ever been made. In 1935 Gurin *et al.*[20] reported a case of complete arterial obstruction to the right leg which was relieved by entering the external iliac artery on its uninvolved side, incising the intima and media within the dissected channel on the opposite side, and thereby producing a distal re-entry. The patient survived the operation for six days. During that period, vascular insufficiency of the leg was never again apparent.

If surgery is contemplated, re-entry should be attempted at the lowest extent of the dissection. The dissection extends into the abdominal aorta in more than 60% of the cases. It is localized above the diaphragm in less than 30% of the cases. The presence of hematuria, neurological findings, the location of the back pain, pulse changes in the femoral arteries, and the like, coupled with roentgen vascular studies, could be used as guides in the choice between an intra-abdominal or intrathoracic approach. An abdominal approach would probably be possible in more than 80% of the cases (table 5).

TABLE 5.—*Surgical Possibilities in Patients Surviving the First 48 Hours**

Total Number of Cases	115
Surgery of No Help:	
Because of natural re-entry	25**
Because patient died of unrelated causes***	4
Possibly Helped:***	
No proximal intimal rupture	16
Dissection of only the ascending aorta and/or arch	11
Related myocardial infarct caused death	4
Related intracranial accident caused death	2
Related uremia caused death	2
Re-entry, but not at distal extent	2
Helped by Surgery:***	
Thoracic approach	8
Abdominal approach	41

*Provided the diagnosis is made soon enough.
**Time factor here was difficult to evaluate; would surgical re-entry be superior to spontaneous?
***All cases (90) in which no distal re-entry ever occurred were considered.

Once the vessel is in view, the decision should not be too difficult. Some of the cases might not be amenable to surgical treatment due to the gross friability of the aortic wall. However, the degree of this pathologic change is usually more pronounced in the proximal rather than the distal region of the dissection.

In how many patients might the surgical production of re-entry be of value? The mean survival time is probably about three to four days; about 40% of the patients fail to survive the first 48 hours. If one assumes that only rarely would surgery be attempted in less than 48 hours, table 5 illustrates approximately the number of cases in which it might be beneficial. The 25 cases with re-entry are misleading; without a necropsy, the time of re-entry is unknown. Certainly table 2 suggests that if the diagnosis is made within two to four weeks after onset, explo-

ration should not be interdicted because of the concern that re-entry has already occurred. Whether or not surgically producing re-entry would help in the second group of patients in table 5 is debatable. Logic suggests, however, that the occurrence or progression of myocardial, cerebral, or renal impairment would be an indication for trying to rapidly relieve the indirect cause; namely, pressure build-up in the dissected channel because of its inability to empty. If one accepts re-entry as the best healing mechanism, then there was a clear-cut indication for surgical intervention in 49 cases (about 43%) of the 48-hour survivors. Thus, provided the diagnosis is made in at least 48 hours, surgical intervention should be possible in about one out of every four cases (49 of 178) of dissecting aneurysms.

Any attempt at surgical intervention must be done without delay. The diagnosis, however, is not always easy. Levinson *et al.*[4] have summarized the diagnostic criteria most excellently. The three conditions most commonly diagnosed instead of dissecting aneurysm are: 1. acute cardiac disease (particularly myocardial infarction) ; 2. cerebrovascular accident; and 3. an acute abdominal condition. The great severity of the pain, any inequalities of the pulse and blood pressure on the two sides, a widely fluctuating blood pressure on repeated checks at short intervals, the development of a new or changing aortic diastolic murmur, no or nonspecific changes in serial electrocardiograms in the face of profound distress, hematuria, and a possibly widened or widening supracardiac shadow on chest roentogram are all clues suggesting the true diagnosis if the index of suspicion is high.

If one is contemplating surgical intervention, the use of angiocardiography may be of aid in doubtful cases. This technique has rarely been used in this condition.[19,24] It confirmed the diagnosis in 4 out of the 5 cases in which it was used. The pathology in the cases of Steinberg *et al.* is not adequately described. It is assumed that they were cases of dissecting aneurysms. Perhaps retrograde aortography would be helpful. The disadvantages of these procedures seem to be more than counterbalanced by the unnecessary delay which they may prevent. More study is needed to evaluate the usefulness of these tools in this disease.

At the present time, anticoagulants are considered contraindicated in dissecting aneurysms, the presumption being that such therapy would retard what healing may occur and most certainly lead to continued intramural bleeding, extension of the dissection, and premature rupture. This is possibly true. On the other hand, it could be argued that the development of thromboses in the false channel tends to narrow this passage, cause a localized increase in intramural pressure and aneurysmal dilatation, and in this manner lead to premature rupture. Moreover, anticoagulants have no effect on capillary retraction or endothelial swelling, and only a lessening effect on the agglutination of platelets, which must also be important means of controlling the intramural hemorrhage. Hence, it is felt that the caution against anticoagulants in dissecting aneurysm is in need of re-evaluation. Perhaps they would allow a more widespread dissection to occur. This, of itself, might be beneficial as extensive dissection seems to result in an increased incidence of re-entry and may tend to buffer intramural pressure changes. Furthermore, these patients do not usually die of the dissection *per se;* they die of rupture. Be that as it may, the use of anticoagulants in conjunction with surgical intervention as discussed above would appear worthy of trial. How more effectively could a smooth, amply patent, false channel with its entrance and exit into the aortic lumen be insured?

In conclusion, then, the suggested method of treating dissecting aneurysms of the aorta is as follows: 1. make an early diagnosis, possibly utilizing angiocardiography and retrograde aortography as diagnostic aids; 2. simultaneously, attempt to estimate the extent of the dissection; 3. immediately begin sedation, analgesia, and indicated antihypertensive drugs; 4. surgically intervene without delay and attempt to produce re-entry of the false dissected channel into the true aortic lumen at the lowest possible level; and 5. institute adequate anticoagulant therapy on the second postoperative day.

SUMMARY

The factors affecting immediate and distal survival in 178 cases of dissecting aneurysm of the aorta have been reviewed. The most important single factor seems to be spontaneous re-entry of the dissected channel into the true aortic lumen at a lower level.

In view of this fact, a surgical approach in the treatment of this disease has been suggested.

The use of angiocardiography and possibly retrograde aortography has been urged in establishing early diagnoses.

The use of indicated antihypertensive drugs has been urged. The role of anticoagulants in this disease has been discussed. They may prove to be a useful adjunct to the surgical production of re-entry.

Addendum: Since this article was written, Shaw has reported the second instance of the surgical treatment of dissecting aneurysm of the aorta as suggested above. The patient's cardiovascular status was definitely improved following the operation; however, death supervened on the seventh postoperative day from uremia caused by renal infarction which had occurred with the acute dissection. Shaw, R. S.: Acute dissecting aortic aneurysm, treatment by fenestration of internal wall of aneurysm, New England J. Med. 253:331–334, (Aug.) 1955.

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REFERENCES

1. Shennan, T.: Dissecting Aneurysms, Medical Research Council, Special Report Series, no. 193, London, His Majesty's Stationery Office, 1934.
2. McCloskey, J. F., and Chu, P. T.: Lesions of vasa vasorum and dissecting aneurysms of aorta; analysis of incidence, etiological aspects, pathogenesis, and pathological changes, A.M.A. Arch. Path. 52:132–144 (Aug.) 1951.
3. Etheridge, C. L., Sando, D. E., and Foltz, E. E.: Dissecting aortic aneurysm, Quart. Bull. Northwestern Univ. M. School 25:221–239, 1951.
4. Levinson, D. C., Edmeades, D. T., and Griffith, G. C.: Dissecting aneurysm of aorta: its clinical, electrocardiographic and laboratory features; report of 58 autopsied cases, Circulation 1: 360-387 (March) 1950.
5. Moersch, F. P., and Sayre, G. P.: Neurologic manifestations associated with dissecting aneurysm of aorta, J.A.M.A. 144:1141–1148 (Dec. 2) 1950.
6. Morgagni, G. B.: Seats and Causes of Diseases, Investigated by Anatomy, translated by Alexander, London, A. Miller, and T. Cadele, 1767, vol. 1, p. 808.
7. Laennec, R. T. H.: Traité de l'auscultation médiate, Paris, J. A. Brosson and J. S. Chaude, 1819, vol. 2, p. 411.
8. Gore I.: Pathogenesis of dissecting aneurysm of aorta, A.M.A. Arch. Path. 53:142–153 (Feb.) 1952.
9. Osler, W.: Modern Medicine, Its Theory and Practice, Philadelphia and New York, Lea and Febiger, 1908, vol. 4, p. 468.
10. Jones, A. M., and Langley, F. A.: Chronic dissecting aneurysms, Brit. Heart J. 8:191–199 (Oct.) 1946.
11. David, P., McPeak, E. M., Vivas-Salas, E., and White, P. D.: Dissecting aneurysm of aorta; review of 17 autopsied cases of acute dissecting aneurysm of aorta encountered at Massachusetts General Hospital from 1937 to 1946 inclusive, 8 of which were correctly diagnosed ante mortem, Ann. Int. Med. 27:405–419 (Sept.) 1947.
12. Literature Cases:
    a. 3, 4, 5, 10, and 11 above.
    b. Bauersfeld, S. R.: Dissecting aneurysm of aorta; presentation of 15 cases and review of recent literature, Ann. Int. Med. 26:873–889 (June) 1947.

Beresford, O. D.: Clinical diagnosis of dissecting aneurysm of aorta, Brit. M. J. 2:397–400 (Aug. 18) 1951.

Blain, A., III, and Gerbasi, F. S.: Surgical significance of dissecting aortic aneurysms, Surgery 25:628–651 (April) 1949.

Bourne, G., and Mills, P. J. W.: Dissecting aneurysm of aorta, with cardiograms suggestive of cardiac infarction, Brit. Heart J. 8:181–190 (Oct.) 1946.

Brebner, H.: Dissecting aneurysm of aorta with renal complications, Brit. M. J. 1:394–395 (Feb. 24) 1951.

Campbell, M.: Dissecting aneurysm with survival for three months after rupture into pleura, Brit. Heart J. 8:200–202 (Oct.) 1946.

Cassidy, M., and Pinniger, J.: Healed dissecting aneurysm, Brit. Heart J. 8:130–140 (July) 1946.

Clinicopathological Exercise, New England J. Med. 233:386–389 (Sept. 27) 1945.

Clinicopathological Exercise, New England J. Med. 234:196–200 (Feb. 7) 1946.

Clinicopathological Exercise, New England J. Med. 236:327–330 (Feb. 27) 1947.

Clinicopathological Exercises, New England J. Med. 244:225–229 (Feb. 8), 724–728 (May 10), and 987–991 (June 28) 1951.

Clinicopathological Exercise, New England J. Med. 247:686–689 (Oct. 30) 1952.

Conston, A. S.: Healed dissecting aneurysm, Arch. Path. 48:309–315 (Oct.) 1949.

Ellis, G. M.: Dissecting aneurysm with hemopericardium; report of case, Am. Heart J. 33:860–866 (June) 1947.

Fraenkel, G. J., and Neil, J. F.: Dissecting aortic aneurysm simulating arterial embolism; report of 2 cases, Lancet 1:801–802 (April 29) 1950.

Griffiths, G. J., Hayhurst, A. P., and Whitehead, R.: Dissecting aneurysm of aorta in mother and child, Brit. Heart J. 13:364–368 (July) 1951.

Hartman, H. J., and Shulman, H.: Dissecting aneurysm of aorta, J. Iowa M. Soc. 41: 172–174 (May) 1951.

Henley, P. G., and Gariepy, L. J.: Case reports of dissecting aneurysm, J. Michigan M. Soc. 45:1203–1213 (Sept.) 1946.

Hoskin, J., and Gardner, F.: Silent dissection of aorta, Brit. Heart J. 8:141–146 (July) 1946.

Kinney, T. D., Sylvester, R. E., and Levine, S. A.: Coarctation and acute dissection of aorta associated with pregnancy, Am. J. M. Sc. 210:725–732 (Dec.) 1945.

Kontoff, H. A., and Sears, B. R.: Dissecting aneurysm of abdominal aorta simulating renal disease: case diagnosed ante-mortem, J. Urol. 65:364–367 (March) 1951.

Leitch, W. H.: Dissecting aneurysm with case reports, Bull. School Med. Univ. Maryland 29:7–30 (July) 1944.

Levinson, D. C., Edmeades, D. T., and Griffith, G. C.: Abdominal pain in dissecting aneurysm of aorta, Am. J. Med. 8:474–479 (April) 1950.

Massey, F. C., and Stoer, U. H.: Dissecting aneurysm of aorta associated with atrioventricular nodal rhythm, Northwest Med. 48:702–706 (Oct.) 1949.

Nissim, J. A.: Dissecting aneurysm of aorta: new sign, Brit. Heart J. 8:203–206 (Oct.) 1946.

Palmer, J. D., and Mathisen, A. K.: Dissecting aneurysm of aorta (study of series of 14 cases), Canad. M. A. J. 55:585–595 (Dec.) 1946.

Reich, N. E.: Dissecting aneurysms of aorta: clinico-pathologic correlation of 19 cases, Clinics 3:346–367 (Aug.) 1944.

Rider, J. A., Chriss, J. W., and Herrmann, G. R.: Dissecting aneurysms of aorta; 10 year study, Texas State J. Med. 46:311–315 (May) 1950.

Ritvo, M., and Votta, P. J.: Clinical and roentgen manifestations of dissecting aneurysm of aorta, Am. J. Roentgenol. 52:583–594 (Dec.) 1944.

Sacks, D. R.: Case report of dissecting aneurysm of aorta with cardiac tamponade, Ann. Int. Med. 23:661–666 (Oct.) 1945.

Sando, D. E., and Helm, S.: Acquired coarctation in new channel of healed dissecting aortic aneurysm, Ann. Int. Med. 37:793–802 (Oct.) 1952.

Schnitker, M. A., and Bayer, C. A.: Dissecting aneurysm of aorta in young individuals, particularly in association with pregnancy, with report of case, Ann. Int. Med. 20: 486–511 (March) 1944.

Schraft, W. C., Jr., and Lisa, J. R.: Dissecting aneurysm of aorta with peripheral embolization: case report, Ann. Int. Med. 34: 507–510 (Feb.) 1951.

Scott, R. W., and Sancetta, S. M.: Dissecting aneurysm of aorta with hemorrhagic infarction of spinal cord and complete paraplegia, Am. Heart J. 38:747–756 (Nov.) 1949.

van Meurs, D. P.: Surgical significance of aortic dissecting aneurysms; report of 3 personal cases with 2 correct ante-mortem diagnoses, Brit. M. J. 2:599–601 (Sept. 25) 1948.

Wainwright, C. W.: Dissecting aneurysm producing coronary occlusion by dissection of coronary artery, Bull. Johns Hopkins Hosp. 75:81–94 (Aug.) 1944.

Warren, A. S., and McQuown, A. L.: Dissecting aneurysms, Am. J. M. Sc. 215:209–219 (Feb.) 1948.

c. Lindeboom, G. A., and Bouwer, W. F.: Dissecting aneurysm (and renal cortical necrosis) associated with arachnodactyly (Marfan's disease), Cardiologia 15:12–20, 1949.

13. Necropsy numbers of these cases: N–42–420, N–47–243, and N–51–148.

14. Necropsy numbers of 17 cases used: N–39–494 and 542; N–41–31, 284, and 501; N–42–208 and 316; N–44–267; N–47–188; N–48–503; N–50–616; N–51–488 and 671; N–52–213, 478, 483, and 560.

15. Necropsy numbers of these cases: N–42–304, N–50–619, and N–52–121.

16. Mote, C. D., and Carr, J. L.: Dissecting aneurysm of aorta, Am. Heart J. 24:69–87 (July) 1942.

17. Gore, I., and Seiwert, V. J.: Dissecting aneurysm of aorta; pathological aspects; analysis of 85 fatal cases, A.M.A. Arch. Path. 53:121–141 (Feb.) 1952.

18. Paullin, J. E., and James, D. F.: Dissecting aneurysm of aorta, Postgrad. Med. 4:291–299 (Oct.) 1948.

19. Golden, A., and Weens, H. S.: Diagnosis of dissecting aneurysm of aorta by angiocardiography; report of case, Am. Heart J. 37:114–118 (Jan.) 1949.

20. Gurin, D., Bulmer, J. W., and Derby, R.: Dissecting aneurysm of aorta; diagnosis and operative relief of acute arterial obstruction due to this cause, New York State J. Med. 35:1200–1202 (Dec. 1) 1935.

21. Cooley, D. A., and DeBakey, M. E.: Surgical considerations of intrathoracic aneurysms of aorta and great vessels, Ann. Surg. 135:660–680 (May) 1952.

22. Alexander, J., and Byron, F. X.: Aortectomy for thoracic aneurysm, J.A.M.A. 126:1139–1145 (Dec. 30) 1944.

23. Morton, J. J., and Scott, W. J. M.: Ligation of abdominal aorta for aneurysm complicated by rupture into retroperitoneal space, Ann. Surg. 119:457–467 (March) 1944.

24. Steinberg, M. F., Grishman, A., and Sussman, M. L.: Nonsyphilitic aneurysm of aorta in individuals under 45 years of age, J. Thoracic Surg. 12:704–713 (Dec.) 1943.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

APPLICATION FOR CERTIFICATION

Applications for certification, American Board of Obstetrics and Gynecology, for the 1957 Part I examinations are now being accepted. Candidates are urged to make such applications at the earliest possible date. The deadline date for receipt of applications is Oct. 1, 1956.

All candidates for admission to the examinations are required to submit with their application a plain typewritten list of all patients admitted to the hospitals where they practice for the year preceding their application or the year prior to their request for reopening of their application.

Application for re-examination, as well as requests for resubmission of case abstracts, must be made to the secretary prior to Oct. 1, 1956.

Current bulletins outlining present requirements may be obtained by writing to:

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Pancreatic Cyst, Internal Drainage by the Roux-en-Y Technique

By MARVIN E. SATTLER, M. D.
Milwaukee

Introduction

PANCREATIC cysts are a somewhat uncommon and serious condition requiring surgery. Recently, new methods of treatment have improved remarkably the mortality and morbidity rates. More and more cases have been treated with success by means of internal drainage. A brief summary of this problem will be presented with a case report.

Classification[1]

1. **Retention Cysts:** These cysts are caused by obstruction of a pancreatic duct, and they have an epithelial lining. Obstructions can be due to calculi, tumors, strictures, or chronic pancreatitis.

2. **Proliferative Cysts:** These cysts, also called cystadenomas, arise from glandular structures. They are usually multilocular. The most common cystic tumors of the pancreas are benign cystadenomas. Cystadenocarcinoma is also seen.

3. **Congenital Cysts:** These cysts are the result of abnormal development. Polycystic disease of other organs is associated with such cysts. Dermoids may be included in this classification.

4. **Hydatid Cysts:** Such cysts are usually found in the liver but may occur in the pancreas.

5. **Pseudocysts:** These are the most common cysts, and they have no true epithelial lining. Trauma and pancreatitis are responsible for their formation. A fibrous capsule is present. Hemorrhagic cysts are due to trauma and are classified as pseudocysts.

Symptoms and Signs

Symptoms of pancreatic cyst depend on the cause and severity of the disease. Abdominal pain, vague abdominal distress, and dyspepsia may occur. Frequently, there is a mass in the epigastrium. If the cyst is in the head of the pancreas, it may cause common duct obstruction. X-ray studies are of primary importance in the diagnosis of this disease. Barium studies of the stomach, small bowel, and colon will often show the tumor mass. The duodenal sweep will be enlarged by cysts involving the head of the pancreas. An intravenous pyelogram may be necessary to differentiate it from the kidney. Pancreatic cysts may also be confused with other retroperitoneal tumors, liver enlargements, perirenal masses, mesenteric cysts, gastric tumors, and kidney tumors.

Treatment

Management of a pancreatic cyst requires a surgical procedure. There are three major methods used. The first is total excision of the cyst. This is the most ideal method and, if at all possible, it should be attempted. In only about 25% of the cases can excision be accomplished safely. According to Catell,[2] retention cysts are best treated by this method because of the lack of inflammatory reaction. Neoplastic cysts demand complete excision due to the danger of malignant degeneration and metastasis. Large cysts of the body and tail of the pancreas lend themselves to this procedure very well.

External drainage is still one of the simplest and safest methods and results in a low mortality rate (4 to 6%). It can be done with simple drainage or by marsupializing the cyst wall to the peritoneum. This procedure causes a pancreatic fistula, recurring cyst formation, and severe electrolyte imbalance. In order to prevent these complications, internal drainage has been introduced. This procedure evidently was used after following cases of pancreatic cysts which had ruptured spontaneously into a neighboring viscus. These patients did well and had no excoriation of the skin, no fistula or cyst formation, and no electrolyte imbalance.

The procedures used for internal drainage have been pancreaticogastrostomy, cystoduodenostomy, or pancreaticojejunostomy. Anastomosis of the cyst to the jejunum is the simplest, and it offers dependent drainage. It can be done by a small loop anastomosis between the cyst and jejunum with a jejunojejunostomy, or by the Roux–en–Y technique. The distal end of the Roux–en–Y loop

is anastomosed to the cyst through an opening in the transverse mesocolon. The proximal end is anastomosed to the distal jejunal loop by an end-to-side anastomosis. Complications of this procedure include leakage of the suture line with peritonitis, recurrence of the cyst, and reflux of the intestinal contents into the cyst. This reflux, however, is not usually evident when the Roux–en–Y method is used.

Doubilet and Mulholland[3] have reported the use of sphincterotomy as a method of drainage of the common duct and pancreatic duct systems. They have found that by relieving the spasm or obstruction at the sphincter of Oddi, retention cysts can be cured. This method has been used since 1948 with increasing success. Except in experienced hands, it is technically more difficult; however, it offers great promise.

The following case report is an example of the success of internal drainage by the Roux–en–Y method.

Case Report

Mrs. R. R., a 58-year-old white female, was first admitted to the hospital on Aug. 4, 1954, complaining of a right upper quadrant pain of 24 hours' duration. She also had nausea and vomiting. There was no food dyscrasia, jaundice, constipation, diarrhea, melena, or weight loss.

The patient's past history revealed that in 1942 she had been told that she had an enlarged liver. She had had no previous surgery. Physical examination revealed marked tenderness in the right upper quadrant with spasm and some rigidity. The bowel sounds were hypoactive, and the abdomen was distended. It was noted that the patient had many café au lait spots on her abdomen. The blood pressure was 160/90, and the pulse rate was 90. The remainder of the physical examination was essentially negative.

Admission laboratory work revealed: white blood cell count, 20,800; nonsegmented cells, 13; segmented cells, 60; lymphocytes 4; monocytes, 5; hemoglobin, 16 gm. Urine, amber and clear; specific gravity, 1.030; reaction, acid; albumin, 3 plus; sugar, positive to 6 drops (¼%); many casts and bacteria; 1 to 3 white blood cells and occasional red blood cells. Blood sugar, 185 mg.; nonprotein nitrogen, 60 mg. Serum chlorides, 105 mEq.; carbon dioxide combining power, 26.4 mEq.; serum bilirubin, 1.94 mg.; serum sodium, 14.3 mEq.; serum potassium, 4.1 mEq.; serum amylase, 919 mg.; serum calcium, 9.1 mg. Stool, positive for occult blood. The urine culture and smear contained cocci.

X-rays of the abdomen revealed a reflex ileus with many stones visible in the gallbladder. An electrocardiogram showed a sinus tachycardia. The patient was placed on intravenous fluids with insulin covering the glucose, Wangensteen suction, 100 mg. of Banthine given intramuscularly four times a day, and intramuscular terramycin. She improved under medical management and was discharged on Aug. 14, 1954.

She was readmitted four weeks later for surgery of the gallbladder. The blood count and urine were normal on this admission. The blood sugar was 123 mg., the nonprotein nitrogen 33.7 mg. The patient was taken to surgery, and an enlarged gallbladder filled with many small stones was found. The cystic duct was of a small caliber; most of the stones in the gallbladder were larger than the cystic duct lumen. An operative cholangiogram was done by placing a No. 6 ureteral catheter into the cystic duct and injecting 15 cc. of Diodrast. A normal ductal system was reported except for some enlargement of the pancreatic duct which was also visualized. The pathologic diagnosis was chronic atrophic cholecystitis and cholelithiasis. The patient made an uneventful recovery and was discharged on Sept. 15, 1954.

She felt extremely well for the next three months but then began to complain of weight loss, a full feeling in her abdomen, and generalized aches and pains.

An epigastric mass was found on physical examination, and an upper gastrointestinal series showed the presence of a mass in the region of the pancreas which was causing a marked depression of the transverse colon. This mass was diagnosed as a pancreatic cyst. The patient was readmitted on Jan. 20, 1955, for further surgery (fig. 1).

On Jan. 25 she was taken to surgery; and a large, thick-walled pancreatic cyst was found in the lesser omental cavity, causing the transverse colon to be depressed and the greater curvature of the stomach to be elevated. A Roux–en–Y anastomosis was done. The distal loop of the proximal jejunum was anastomosed to the dependent portion of the cyst, and the proximal loop was anastomosed to the side of the distal jejunum. The cyst was approximately six inches

Fig. 1—X-ray shows the presence of a mass in the lesser omental space, causing depression of the transverse colon and loss of the normal duodenal sweep.

Fig. 2—X-ray taken about 6 months postoperatively. The mass has disappeared, and the normal contour of the upper gastrointestinal tract has been preserved.

in diameter and contained about three hundred cubic centimeters of a clear serous fluid. The patient had an uneventful postoperative course. On Sept. 23, 1955, another upper gastrointestinal x-ray was made; it showed a normal configuration of the head of the pancreas. The barium moved freely into the jejunum, which showed no particular abnormalities, except for a slight distention in the proximal area. The region of the anastomosis showed good mobility and motility.

Mrs. R. R. has regained the weight she lost, feels well, and is back to her normal routine (fig. 2).

Discussion

The above case report has presented an interesting problem of acute pancreatitis with formation of a pancreatic cyst. This cyst formation followed surgery of the gallbladder, which included an operative cholangiogram showing a relatively normal common duct system. The patient was successfully treated for her acute pancreatitis with conservative medical management. The cholangiogram was reviewed after surgery, and the pancreatic duct was then reported as slightly dilated. No spasm or obstruction was noted at the sphincter of Oddi. During the gallbladder surgery we debated whether or not the common duct should be drained; however, it was felt that it was not necessary in the presence of the normal cholangiogram and would only add an additional hazard to the procedure.

The theories of pancreatic cyst formation have been briefly presented. The pseudocyst found in this case is explained by destruction and obstruction of the epithelial lining of the pancreatic ducts by the acute inflammatory process. Evidently, the dilated pancreatic duct, which was visualized on the operative cholangiogram, indicated some spasm at the sphincter of Oddi which was also a factor in the formation of this cyst.

Doubilet, Poppel, and Mulholland[3] have confirmed the great importance of the sphincter of Oddi in the formation of pancreatic cysts. Their recent work with pancreatography and drainage of the duct of Wirsung by means of sphincterotomy offers much for future diagnosis and treatment of pancreatic diseases.

In their method, after sphincterotomy has been performed, a polyethylene catheter is passed through an opening in the common duct and threaded into the duct of Wirsung.

This catheter is passed to the area of the pancreatic cyst, and serial x-rays are taken of the progress of decompressing the cyst.

At the present time it is generally agreed that the treatment of pancreatic cysts requires a surgical procedure. Internal drainage by means of a jejunal anastomosis to the cyst is the simplest method and, up to the present time, has produced the best results. The Roux–en–Y technique offers greater dependent drainage and less chance for regurgitation of intestinal contents into the cyst. The method of Doubilet and Mulholland,[3] although technically more difficult, may be the ultimate answer to this problem.

Summary

1. A brief summary of the classification, etiology, signs, symptoms, and treatment of pancreatic cysts has been presented.

2. A case report of acute pancreatitis with the subsequent formation of a pancreatic cyst eventually treated by means of a Roux-en–Y anastomosis is also presented.

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REFERENCES

1. Warren, K. W.: Pancreatic cysts, S. Clin. North America 28:753–760 (June) 1948.
2. Catell, R. B.: Partial Pancreatectomy: Excision of Tail and Body of Pancreas, in Surgical Practice of the Lahey Clinic, Philadelphia and London, W. B. Saunders Company, 1951, pp. 556–561.
3. Doubilet, H., Poppel, M. H., and Mulholland, J. H.: Pancreatography, technics, principles, and observations, Radiology 64:325–339 (March) 1955.
4. Adams, R., and Nishijima, R. A.: Surgical treatment of pancreatic cysts, Surg., Gynec. & Obst. 83:181–187 (Aug.) 1946.
5. Gurwitz, J., and Hurwitz, A.: Treatment of pancreatic cysts, Ann. Surg. 128:976–980 (Nov.) 1948.
6. Johnson, T. A., and Lee, W. E.: Symposium on new trends in surgery; pancreatic cyst; report of 5 cases, S. Clin. North America 22:1677–1692 (Dec.) 1942.
7. Maxeiner, S. R., Jr., and Maxeiner, S. R.: Pancreatic cystgastrostomy; discussion and report of case, Surgery 27:919–921 (June) 1950.
8. Migliaccio, A. V., and Laurelli, E. C.: Pancreatic cyst; internal drainage utilizing Roux principle, Surgery 24:54–56 (July) 1948.
9. Poer, D. H., and Stephenson, R. H.: Late results in treatment of pancreatic cysts by internal drainage, Surg., Gynec. & Obst. 89:257–263 (Sept.) 1949.
10. Rosi, P. A.: Internal drainage of pancreatic cyst by means of Roux-Y anastomosis to jejunum, A.M.A. Arch. Surg. 63:119–127 (July) 1951.
11. Zaoussis, A. L.: Pancreatic cysts—surgical treatment especially by use of internal drainage with report on 6 cases, Ann. Surg. 138:13–23 (July) 1953.

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The Problem of Acute Anuria

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THE problem of acute anuria is a complex one and taxes the physician's diagnostic acumen and therapeutic skill. There are several causes of this type of diminished urine formation which are discussed below.

Prerenal kidney failure may be encountered in patients with congestive heart failure or prolonged shock. It is the result of deviation of the blood supply from the kidney and does not imply kidney damage. The treatment for this condition is the prompt correction of the underlying circulatory disturbance.

The causes of renal parenchymal failure may be subdivided into two common types of acute kidney damage. Acute glomerulonephritis may occasionally be associated with such a marked inflammatory reaction of the glomeruli as to interfere with filtration, resulting in oliguria and azotemia. In occasional instances this may be of sufficient intensity to cause death. On the other hand, lower nephron nephrosis is a term recently popularized for acute tubular nephritis from which the kidneys recover completely, provided the patient survives the usual 10- to 14-day phase of anuria. There are numerous causes of this syndrome which are tabulated in table 1.

TABLE 1

Crush Syndrome—Myoglobin Nephrosis
Acute Hemolysis—Hemoglobin Nephrosis
Incompatible blood transfusion
Transurethral prostatic resection
Burns
Hemolytic toxins
Chemical
Infectious
Acute Tubular Anoxia
Prolonged shock
Postpartum cortical necrosis
Specific Tubular Poisons
Mercury
Carbon tetrachloride
Hepatorenal Syndrome

The diagnosis of lower nephron nephrosis depends upon the knowledge of the occurrence of one of these precipitating factors, first, by the appearance of shock; second, the phase of oliguria and increasing azotemia; and, third, either by death or by the spontaneous appearance of diuresis, usually within a period of two weeks. Careful medical management, particularly during the phase of anuria, minimizes the mortality of this disease.

Postrenal oliguria and azotemia may accompany obstructions within the lower urinary tract. These conditions can usually be corrected by proper urologic investigation and treatment.

The acute renal failure which is associated with anuria, or oliguria associated with acute glomerulonephritis or lower nephron nephrosis poses peculiar problems in medical management. The most common error is the administration of too much water. This leads to edema, congestive heart failure, and hypertensive encephalopathy. These complications are related in part, at least, to the excessive use of parenteral or oral fluids in an effort to "make the kidneys work." In acute glomerulonephritis, the oliguria resulting from excessive inflammatory reaction in the glomeruli cannot be corrected by forcing fluids. Similarly, in the case of lower nephron nephrosis with primary tubular damage, diuresis cannot be produced by forcing fluids. Since urine cannot form in either of these situations until some degree of healing spontaneously occurs, it is necessary that water, electrolytes, and calories be supplied in a manner that will minimize the effect of this loss of excretory function.

In the anuric patient a daily intake of 750 cc. of water is sufficient to compensate for the usual insensible water losses and will not lead to overloading the circulation. When excessive sweating or vomiting or copious watery diarrhea is present, this requirement may be increased slightly. Evidence of overloading the circulation is manifested by pulmonary edema, a gallop rhythm to the heart sounds, or peripheral edema. It is then that fluids may be withheld completely for two or three days. The insensible fluid loss during this time may result in sufficient dehydration to reduce the intensity of these dangerous complications. One-half of the

volume of blood given in transfusion should be considered as part of the daily water intake. The administration of greater amounts of fluid than this optimum leads to overhydration and the complications of edema, congestive heart failure, and hypertensive encephalopathy.

In the discussion of electrolyte requirements, it must be remembered that sodium chloride is excreted primarily by the kidneys. In the presence of anuria no sodium chloride is lost and, therefore, none need be administered. "Physiologic saline" solutions are decidedly unphysiologic in this situation and can only cause harm. The acidosis of uremia is usually not sufficiently severe to warrant the use of alkalies. Since available alkalies are sodium salts, their effect is similar to the effect of too much sodium chloride. Acidosis itself is not particularly harmful to the restoration of kidney function and, therefore, the administration of alkalies should be limited to those patients with acidosis sufficiently severe to cause distressing hyperventilation.

Complete fasting results in the destruction of body protein and the formation of considerable acid products of metabolism. The administration of carbohydrates reduces this destruction considerably and delays the development of acidosis. If the patient can tolerate it, the diet should consist of carbohydrate and fat, but with a minimum amount of protein. When nausea and vomiting interfere with the diet, a minimum of 100 gm. of glucose should be included in the daily allotment of fluid.

The greatest hazard for the anuric patient is overtreatment. Since the kidneys will not function until the pathologic process is healed sufficiently, the physician must school himself in a minimal "do nothing" policy as outlined. When, in spite of this, the patient's condition appears to be deteriorating, one may consider the use of the artificial kidney.

THE MECHANICS OF THE ARTIFICIAL KIDNEY

Reduced to its simplest terms, the artificial kidney consists of 100 feet of cellophane tubing wound around a large cylinder which rotates in a dialyzing bath solution. Pumps, air traps, filters, and temperature controls maintain the flow of blood, protect against emboli, and prevent chilling. After sterilization of all tubing and filters, the apparatus is assembled and primed with blood. Simultaneously, using local anesthesia, the surgeon cannulates a large vein and then the radial artery with plastic tubing by direct surgical exposure. After hemostasis is complete, the patient is given 100 mg. of heparin intravenously and the cannulae are attached to appropriate ends of the apparatus. Donor blood immediately flows into the vein as arterial blood is withdrawn from the patient, thus avoiding any significant change in blood volume. For about five hours the operating team constantly regulates the flow into and from the apparatus, changes the dialyzing fluid when necessary, guards against leaks in the system, and observes the patient's reactions. At the termination of the procedure, protamine is administered to counteract the effect of heparin and the cannulae are removed, leaving approximately the same amount of blood in the cellophane tubing as was initially introduced to prime it.

One important purpose of the artificial kidney is the removal of waste products from the blood—the excretory function. Of equal concern is the problem of maintaining the concentrations of electrolytes and water within the body fluids—the retentive function. These two phases of the problem will be dealt with separately.

Excretory Function

Nonprotein nitrogen diffuses into the water bath at a relatively rapid rate. Its concentration in the blood may be reduced as much as 200 mg. % in a five-hour period of dialysis, depending upon the initial level. Urea, creatinine, and uric acid are also dialyzed in proportion to their initial concentrations.

Current medical interest in the toxic factor of uremia is centering around the potassium ion. There appears to be a correlation between the clinical symptomatology of uremia and the concentration of potassium in the plasma. While determinations of the concentration of potassium are not generally available, the electrocardiogram may be helpful. As the concentration of potassium in the plasma rises, there is a progressive occurrence of high-peaked T waves; depression of the ST interval; diphasic T waves; disappearance of the P waves; and, finally, intraventricular block. Tracings return to normal as potassium is dialyzed into the bath.

Retentive Function

Ideally, the dialyzing bath should have the same ionic composition as the blood stream. If distilled water were used, the loss of essential electrolytes into the bath by diffusion, and the migration of water into the plasma would quickly be fatal. Accordingly, the bath solution is composed of appropriate concentrations of sodium, magnesium, chloride, and bicarbonate. A greater difficulty is encountered in maintaining osmotic pressure since proteins cause foaming and accumulate in gummy layers. A practical substitute is the use of glucose in rather high concentrations. Although glucose does dialyze into the blood during the procedure, the elevation of the concentration of sugar in the blood and the reduction of the osmotic pressure of the bath solution during the period of dialysis is not sufficient to cause difficulties.

A certain flexibility is possible in the composition of the bath solution, and this has been found to be of value in patients who have received too much salt or water. Increasing the osmotic pressure of the bath solution by addition of glucose effectively draws water out of the circulation and combats overhydration. Similarly, sodium and other electrolytes tend to dialyze out of or into the blood stream depending upon their concentration in the blood in relation to the approximately normal concentration initially present in the bath water.

The effectiveness of the artificial kidney is exemplified by the results in one of our cases, which is outlined in the following case report. It should be emphasized, however, that the results of conservative management are usually so effective that artificial dialysis is rarely indicated.

CASE REPORT

A 33-year-old woman was hospitalized in the fifth month of pregnancy because of a shaking chill followed by a spontaneous abortion. When catheterization was done prior to manual removal of the placenta, approximately 100 cc. of black urine was obtained. There was no subsequent voiding. The red blood cell count was 750,000, and the patient received a 2,000 cc. blood transfusion. On the second day of anuria the nonprotein nitrogen level was 124 mg. and the creatinine level 6.4 mg. per 100 cc. There was moderate acidosis, with carbon dioxide concentration of 13 mEq. per liter. The serum electrolyte levels were essentially normal. The serum hemoglobin was 1,680 mg., and the serum bilirubin was 6.8 mg. per 100 cc., 87% of which was the direct-reacting type. The whole blood hemoglobin was 11 gm., and the erythrocyte count was 3,560,000. Extensive investigation of the blood failed to reveal any immune or irregular isoantibodies. The acid fragility test was normal.

Treatment consisted of a diet which was limited to 35 gm. of protein and was low in potassium and sodium. The total fluid intake was limited to 750 cc. daily, including dietary liquids. Persistent nausea and vomiting kept the total caloric intake low. The pigment portion of the hemolyzed erythrocytes was excreted in the bile as evidenced by the numerous liquid, foul, black stools during the first two weeks of anuria. With this, the bilirubin concentration in the serum fell progressively to 2.0 mg. and 0.9 mg. per 100 cc. and the serum hemoglobin to 132 mg. and 7.0 mg. per 100 cc. on the fourth and eighth days respectively.

The clinical manifestations of uremia became progressively more serious after the seventh day. Extreme weakness and urea odor to the breath were noted. Repeated emesis occurred, and pain in the anterior chest was accompanied by the appearance of a pericardial friction rub and right bundle-branch block. Fluids were administered parenterally in the form of dextrose and distilled water to cover insensible and gastrointestinal losses. Although the concentrations of electrolytes in the serum on the seventh day were sodium 132.5 mEq. and chlorides 87 mEq., and carbon dioxide concentration 14 mEq. per liter, the administration of 1,000 cc. 1/6 molar sodium lactate exerted no detectable beneficial effect.

On the twelfth day of anuria the situation was desperate. The patient was extremely restless and apprehensive, complaining of numbness and paresthesia of the extremities. Several mild convulsions occurred. The maximum blood pressure was 120/64, with a pulse rate of 64. The nonprotein nitrogen of the blood was 296 mg. and the creatinine level 15.5 mg. per 100 cc. The serum potassium was 6.9 mEq. and the carbon dioxide was 13 mEq. per liter.

The patient's blood was dialyzed in the artificial kidney for a period of four and one-half hours on the twelfth day, after which the nonprotein nitrogen of the blood was 180 mg. and the creatinine 11.4 mg. per

100 cc. The concentration of potassium in the serum had fallen to 5.2 mEq. per liter. After this, the patient's color was considerably improved; she was much more alert but remained very weak and listless. No further twitchings or convulsions were present. Thirty-six hours after dialysis, chemical examination of the blood revealed a "rebound," with a nonprotein nitrogen level of 266 mg.; the creatinine level was 4.1 mg. per 100 cc. The patient remained anuric.

Difficulty was encountered in maintaining an accurate check of fluid and electrolyte intake and output because of recurrent vomiting and incontinence of feces. The concentration of serum sodium fell progressively. On the seventeenth day of anuria, intravenous therapy was started. On the basis of the concentration of serum sodium of 122.5 mEq. per liter and a total body water of 35 liters (estimated weight 50 kg.), 500 cc. of 5% saline was administered without untoward effect. The concentration of sodium in the serum the next day was 137.5 mEq. and serum chlorides 96.9 mEq. per liter. In addition, the patient received on the seventeenth and eighteenth days of anuria 1,000 cc. of blood, 2,000 cc. of 5% dextrose in saline, 50 cc. of calcium gluconate, and 200 cc. of dextrose in water, making a total of 3,250 cc. of liquid in 48 hours. This was given deliberately to correct a predicted extracellular fluid and electrolyte deficit. In spite of repeated examinations during the course of this therapy, pulmonary edema was precipitated without warning. Emergency treatment of this complication consisted of administration of positive-pressure oxygen, the removal of 500 cc. of blood by phlebotomy, and the application of tourniquets to the extremities for a period of 12 hours. Anuria persisted.

By the twenty-first day of anuria, azotemia was again extreme; the nonprotein nitrogen level was 272 mg., the creatinine level 16 mg. per 100 cc., and the carbon dioxide 13 mEq. per liter. It became technically impossible to determine concentrations of potassium because of excessive fibrin. The patient was acidotic, restless, apprehensive, and confused, and at times appeared to have hallucinations. In desperation her blood was again dialyzed on the artificial kidney for nine and one-half hours. After dialysis the nonprotein nitrogen level was 112 mg., the creatinine level 9.9 mg. per 100 cc., and the carbon dioxide 22 mEq. per liter of serum.

Approximately twelve hours after this last dialysis, diuresis began; and 300 cc. of urine appeared per catheter during the first 24 hours. The volume of urine increased gradually over the next five days to 2,000 cc. daily, and this volume of urine was maintained daily thereafter. The "rebound" 36 hours after the second dialysis revealed the concentration of nonprotein nitrogen in the blood to be 206 mg. and creatinine 12.3 mg. per 100 cc. These values remained elevated for the next six days in spite of diuresis and then gradually declined. Normal values of nonprotein nitrogen and creatinine were observed for the first time 26 days after the onset of diuresis.

The patient was discharged from the hospital 36 days after her initial hemolytic episode. The nonprotein nitrogen level was 136 mg. and the creatinine level 5.7 mg. per 100 cc. Her mental status had improved; and, except for persistent weakness, lethargy, and nocturia, her condition had improved markedly.

Examination four months later revealed that persistent nocturia, with voiding two or three times a night, was still present. The maximum concentration power in the urine was 1.016, and the phenolsulfonphthalein excretion was 50% in 30 minutes. When the patient was seen for the six-month follow-up, all urinary symptoms had disappeared. The urea clearance test was 74% of normal. Examination at the end of nine months revealed no abnormal symptoms or signs. The blood pressure was 126/76. The ocular fundi were normal. The patient was able to concentrate her urine to a specific gravity of 1.025 with no reaction for albumin. Fifteen minutes after the injection of phenolsulfonphthalein, 90 cc. of urine containing 30% of the dye was collected. The urea clearance was 73% of average normal. (Previously reported in Archives of Surgery, 67:431, Sept., 1953.)

CONCLUSIONS

The treatment of uremia and anuria rests upon established medical principles, which, if carefully followed, will result in a lowering of mortality, particularly in acute reversible tubular disease. The greatest danger to the patient is the overzealous administration of sodium salts and water. The artificial kidney is a practical means, in the hands of those experienced in its use, of temporarily reducing the degree of uremia and combating circulatory complications.

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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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Cardiac Arrest

By D. W. BARROW, M. D.,* and R. I. DOBERNECK**
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CARDIAC arrest is a terrifying, frustrating tragedy more satisfactorily prevented than corrected. The reported incidence varies widely. Stephenson[1] found 1,200 cases which occurred during 517,151 operations performed in 30 different centers. Rovenstine *et al.*[2] reported on 9 consecutive cardiac accidents which occurred during 28,000 major operative procedures. Johnson and Kirby[3] reported 13 patients with cardiac standstill or fibrillation during 70,000 spinal or general anesthesias given between 1946 and 1953, or an incidence of one in each 5,384 anesthetizations. Sadove[4] reported 1 case in each 1,000 operations. Lahey[5] estimated that cardiac arrest could be anticipated twice a year on a busy surgical service, and Glenn[6] believed that cardiac arrest occurs about 5,000 times each year in the United States. At the Milwaukee County Hospital, cardiac arrest was encountered 12 times in the past four years. During surgery upon the heart itself, arrest and/or fibrillation is more frequent. Blalock reported an incidence of 5.5% in patients undergoing surgery for pulmonic stenosis.

Cardiac arrest has been encountered in patients with every type of lesion. In the group reported by Lahey it occurred during three chest, four abdominal, two thyroid, one sympathetic nervous system, and one brain operation. It also occurred once during laryngoscopy and once during induction of anesthesia.

At the Milwaukee County Hospital cardiac arrest was encountered during closure of the incision following cholecystectomy, during a nephrectomy, prior to a vein stripping, during bronchoscopy, during a hysterectomy, three times prior to amputation of a toe, once during a gastrectomy, once prior to an arterial embolectomy, and once during closure of a hernia repair.

Cardiac arrest has been reported in association with all types of anesthesia. At the Milwaukee County Hospital, Pentothal is used with great frequency for induction, and all but 2 of these patients received Pentothal, to which cyclopropane was frequently added. We cannot assess the etiologic importance of these agents, but we have been impressed by the frequency with which anesthesia using a multiplicity of agents, one of which is usually Pentothal, is made suspect by others.

Cardiac arrest occurs in all age groups, being particularly frequent in the young and the very old. In fact, 20% of all patients who experience cardiac arrest are less than 10 years of age (Stephenson),[1] an incidence which becomes the more significant in relation to the small number of pediatric operations performed.

In 1,200 reported cases, 61% were males and 39% were females in contrast to the slightly greater frequency of surgery in females than in males.

Cardiac arrest is apparently of two types. The first is anoxic and can be demonstrated in the laboratory.[7] When the trachea of a laboratory animal is completely occluded, the heart rate speeds up; cyanosis develops; and the heart dilates, then slows, and finally comes to complete arrest. If tracheal obstruction is relieved prior to arrest, or even immediately afterward, vigorous heart action returns, cyanosis clears, and the heart size returns to normal. If anoxia is allowed to continue for a short time after arrest, the heart beat does not recover spontaneously but must be induced by cardiac compression. The same chain of events may be produced in the experimental animal by very deep chloroform, ether, or Pentothal anesthesia.

The second mechanism of cardiac arrest is perhaps related to the so-called vago-vagal reflex and probably potentiated by metabolic alterations.[8,9] Again in the laboratory, chronic anoxia, coronary disease, digitalis intoxication, increased serum potassium, altered pH of the blood, and particularly increased carbon dioxide have been shown to

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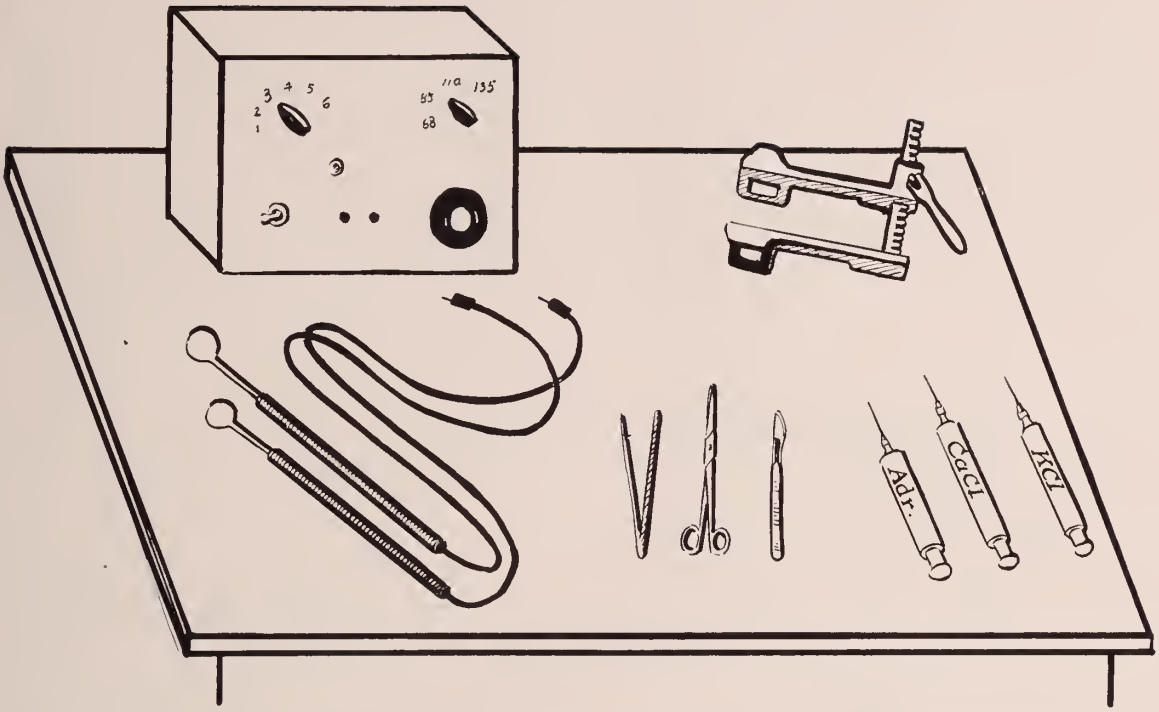

Fig. 1—Cardiac arrest tray containing a defibrillator with sterile blades, sterile rib retractor, sterile scalpel for opening the thoracic cage, and sterile forceps and scissors for incising the pericardium, as well as previously loaded and capped syringes equipped with appropriate needles and containing 1:10,000 Adrenalin solution, 10% calcium gluconate or chloride, and 10% potassium chloride.

so potentiate vagal irritation that arrest or fibrillation might well be expected from stimuli which in normal individuals would be innocuous.

Sudden absence of pulse and blood pressure without prodromal signs, in any patient, is almost diagnostic of cardiac arrest. Cyanosis may occur, and wide dilation of the pupil is constant. In patients with shock or vasomotor collapse the pulse and blood pressure may be absent; but the history helps in differential diagnosis, and auscultation of even a faint heart beat eliminates a diagnosis of cardiac arrest. When doubt persists, exploratory incision is indicated, for recovery from cardiac arrest is dependent upon reinitiation of the heart beat prior to irreversible damage to nerve tissue by anoxia to which it is completely intolerant. In fact, electroencephalographic changes have been demonstrated within two seconds (Glenn);[10] and irreversible changes occur within three and one-half minutes or less in patients without preceding anoxia.

Barber and Madden collected reports on 143 patients with cardiac arrest, 48 or 33% of whom recovered. Lahey and Ruzicka had 13 cases with 5 recoveries, or 38%. But such favorable results require thorough organization (fig. 1), without which recovery is rare except when arrest occurs in thoracic or cardiac operations where diagnosis is instant (Harken). Neurological damage may persist in those whose life returns, and the patient becomes a vegetable.

Since success is dependent upon instantaneous restoration of the heart beat, there is little time for intracardiac injection of drugs, provocative pounding on the chest, and needling of the heart; and more than a few seconds should not be wasted prior to thoracotomy. Incision through the third or fourth interspace is adequate. If the heart beat is restored by gentle compression, the pericardium need not be opened. If it is not, or fibrillation occurs, the pericardium should be opened and the heart encircled by the palm and fingers to allow maximum compression. Sixty to eighty compressions a minute gives maximum blood flow (fig. 2).

With cardiac arrest spontaneous respiration ceases and artificial respiration, using 100% oxygen, is necessary. However, we have seen spontaneous respiration start again in a patient while compression was

being done and prior to the return of spontaneous heart action.

When asystole persists after a few compressions, injection of 1 cc. or less of 1:1,000 epinephrine diluted in 9 cc. of saline into the left ventricle has been suggested, but Adrenalin may cause fibrillation and should not be used unless cardiac compression is ineffective. As a matter of fact, we have found the return of heart action less of a problem than obtaining contractions of adequate strength, for which the injection of 10% calcium chloride solution is much more effective than Adrenalin.

Cardiac compression should be vigorous for adequate blood flow, but the dilated heart is friable and ruptures easily. Such an accident presumably can be avoided by several

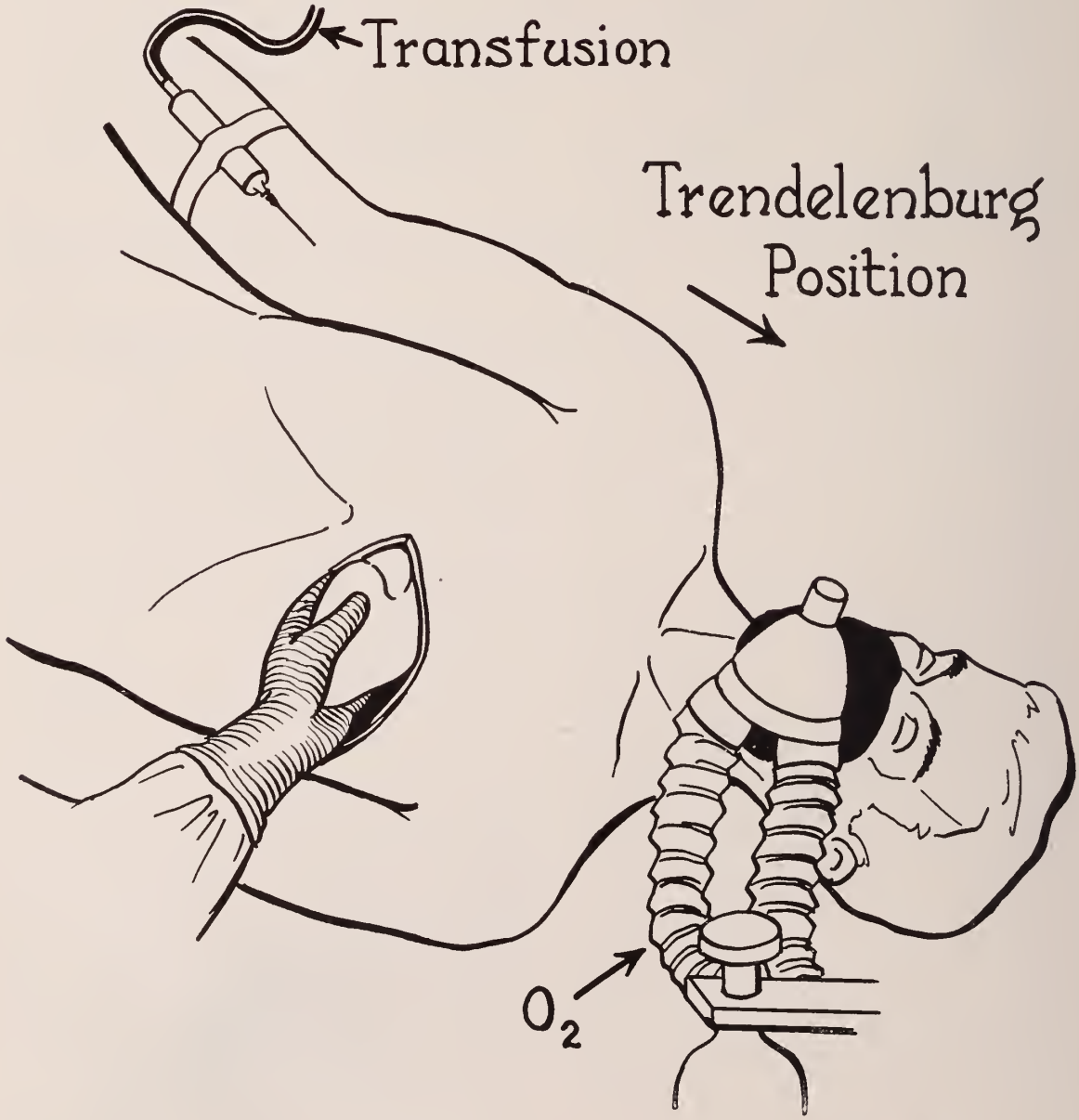

Fig. 2—Treatment of the patient in cardiac arrest by cardiac massage through the opened chest and pericardium. Oxygen is insufflated through an intratracheal tube while a transfusion is given to combat hypovolemia which may result from tissue anoxia and increased capillary permeability. The Trendelenburg position favors maximum blood flow to the cerebrum.

less forceful preliminary compressions to restore some tone to the heart muscle.

In about half the patients who go into cardiac arrest, ventricular fibrillation develops; it has been described as feeling like a bag filled with worms—and it does. Such grossly irregular and incoordinate heart action is ineffective in pumping blood, and massage must continue. If fibrillation continues, the heart gradually wears itself out, becomes cyanotic, and stops in asystole, from which recovery is dubious. Fibrillation can be stopped by the production of temporary complete cardiac arrest through the injection of potassium chloride into the ventricle. A normal heart beat can be reinitiated by cardiac compression after waiting about half a minute. If cardiac compression is started too hastily, however, ventricular fibrillation may recur as soon as the heart beats.

When fibrillation persists after the injection of potassium chloride, cardiac standstill can be produced by electric shock, the equipment for which must be available on a standby basis if it is to be effective. Serial shocks are more effective than a single one.

Spontaneous rhythm can usually be reinitiated in hearts which were previously normal. In those which were already damaged, it is more difficult. In either event, cerebral anoxia is a major problem; and the patients should continue to receive oxygen in maximum concentration after the operation. Some patients will exhibit major neurological abnormalities, including the signs and symptoms of decerebrate rigidity, and still recover completely in a day or two. Unfortunately, others develop such extensive cerebral damage from anoxia prior to the reinitiation of the heart beat that they die in a day or two despite the return of adequate cardiac action. Hyperpyrexia occurs frequently in such patients prior to death.

Case Reports

Case 1—A. C., a 37-year-old white female, had massive hemorrhage from peptic ulceration. Anesthesia was induced with cyclopropane. Soon after the beginning of surgery the patient developed hypotension and bradycardia. The blood pressure and heart beat returned to normal with conservative measures, but a short time later the heart beat stopped completely. The patient did not respond to cardiac massage, procaine, and Adrenalin. She received 11 transfusions prior to surgery, but hypovolemia probably played a large part in her cardiac standstill.

Case 2—N. L., a 58-year-old white female with cholecystitis, had an uneventful cholecystectomy and appendectomy. During closure of the incision, cardiac arrest occurred and was recognized immediately. Transdiaphragmatic cardiac massage, and later massage through the open chest, was done. Pure oxygen was readily available through the intratracheal tube which was in place. Calcium gluconate was injected into the ventricle. Adequate cardiac action returned, and the patient's postoperative convalescence was entirely uneventful. Her anesthesia was induced with Pentothal and maintained with nitrous oxide and oxygen. She received 12 mg. of curare during the operation.

Case 3—C. M., a 63-year-old white male, had cardiac arrest immediately upon induction of anesthesia with Pentothal prior to ligation and stripping of varicose veins. The chest was opened and the rhythm restored after cardiac massage. The patient received Pronestyl and calcium gluconate intracardially. This was effective temporarily, but the blood pressure progressively became lower and the patient expired on the fourth postoperative day, at which time a Babinski reflex was present bilaterally. Autopsy showed several endocardial hemorrhages, the largest of which was 3 mm. in diameter. There was a small myocardial infarct as well.

Case 4—S. O., a 61-year-old white male, had topical anesthesia of 2% Pontocaine prior to bronchoscopy. Convulsions developed, and he was given 5 cc. of Pentothal. He immediately went into cardiac arrest, which responded to cardiac massage through the open chest, Pronestyl, and calcium gluconate. Consciousness returned, and he developed convulsions as soon as he came out of anesthesia. An electrocardiogram taken immediately after the episode of cardiac arrest showed a right bundle-branch block; one taken prior to the operation had been normal. Generalized and localized convulsions continued, and the temperature rose to 104 F. prior to exitus.

Case 5—M. L., a 43-year-old Negro female with uterine fibroids, developed cardiac arrest during abdominal exploration prior to hysterectomy. Anesthesia had been induced with Pentothal and maintained with ether,

cyclopropane, and oxygen. Cardiac arrest responded to cardiac massage through the open chest, but the patient did not become rational and had convulsions continuously until the time of death on the first postoperative day.

Case 6—P. R., a 29-year-old white female, developed cardiac arrest at the completion of removal of a large renal tumor. She did not respond to open thoracotomy with cardiac arrest or the intracardiac injection of Pronestyl, Adrenalin, whole blood, and caffeine. Anesthesia had been induced with Pentothal and maintained with cyclopropane and oxygen.

Case 7—C. T., a 70-year-old Negro female, was a known diabetic patient with gangrene of the toes. Immediately upon induction of anesthesia with Pentothal and cyclopropane prior to amputation of a toe, she experienced cardiac arrest which responded to cardiac massage, intracardiac Adrenalin, and procaine. The blood pressure varied widely for the next hour, after which time the patient died. An electrocardiogram showed bundle-branch block. There was no preoperative electrocardiogram for comparison.

Case 8—F. W., a 59-year-old Negro male, had anesthesia induced with cyclopropane and oxygen prior to amputation of a toe. There was an immediate cardiac arrest. He did not respond to oxygen and intracardiac Adrenalin. The chest was not opened, and there was no return of cardiac action. The patient's general condition had been satisfactory prior to operation, and one month previously anesthesia for amputation of a toe had been done without difficulty.

Case 9—C. S., a 73-year-old white female, had mild diabetes and gangrene of the tip of the right third toe. During the induction of anesthesia with Pentothal, cardiac arrest occurred which did not respond to cardiac massage. There was no previous known impairment of her heart.

Case 10—P. K., a 48-year-old white female, had arterial occlusion of the right popliteal artery. Anesthesia was induced with Pentothal and reinforced with cyclopropane. Cardiac arrest occurred almost immediately and did not respond to cardiac massage and drugs. Autopsy showed a recent coronary occlusion with a mural thrombus of the myocardium and a small embolus to the popliteal artery.

Case 11—D. G., a 38-year-old colored male, was undergoing herniorraphy for a recurrent hernia on the right. Anesthesia had been induced with Sodium Pentothal and maintained with cyclopropane, ether, and oxygen. The repair of the hernia required almost two hours; at the completion of the operation it was noticed there was no pulse and no blood pressure. The thorax was opened. The heart was dilated in standstill. Levophed and Coramine were injected into the vena cava and calcium gluconate into the ventricle. Cardiac action returned, and the chest was closed. Two hours later the patient remained unconscious, and infusion of Levophed was necessary to maintain adequate blood pressure. Later in the day tracheotomy was done without anesthesia to improve the airway. The patient lived 11 days, during which time he did not regain consciousness. Tachycardia persisted, and the blood pressure was low. The respiratory rate was greatly elevated. The nonprotein nitrogen became elevated and the temperature progressively higher, reaching 105.2 F.

Another patient with cardiac arrest was observed by one of us (D.W.B.) prior to coming to the Milwaukee County Hospital. This occurred during induction of anesthesia with Pentothal preliminary to a fusion of the spine. The patient became cyanotic, and the pupils were widely dilated. Upon opening the chest, it was found that the heart was enormously dilated and soft. Manual compression was followed by spontaneous cardiac rhythm and resulted in immediate reduction in the size of the pupils and the resumption of spontaneous respirations, even though effective cardiac action required continuing manual compression. The pericardium was opened anterior to the phrenic nerve to allow more adequate compression, and calcium gluconate and Adrenalin were injected into the ventricle in an attempt to stimulate contractions. This was followed by fibrillation, which stopped during an asystole induced by potassium chloride but recurred with the return of cardiac action. A single electric shock was ineffective, but a series of three defibrillated the heart. Each of these shocks was of sufficient intensity to cause contraction of all the muscles of the body, and the patient literally "jumped off the table" each time.

Following defibrillation a small amount of calcium gluconate was again injected in the left ventricle, and spontaneous rhythm per-

sisted. The duration of manual cardiac compression had been one hour and twelve minutes. The pericardium was sutured loosely, and the thoracotomy incision was thoroughly irrigated and closed. One million units of penicillin and a gram of dihydrostreptomycin were placed within the pleural cavity prior to closure. Water seal drainage was instituted.

On the evening of the day of operation the patient was disoriented and did not respond to questions; his legs and arms were spastic and held in extension; his reflexes were grossly exaggerated—in short, the picture of decerebrate rigidity. Oxygen was continued by nasal catheter.

On the following morning the patient had improved greatly and the sensorium cleared. He could not remember the events immediately preceding or following his anesthesia induction, and it was difficult to give him a reasonable explanation for there being an incision in his chest instead of one over the lower spine as originally planned.

Summary

Cardiac arrest is not infrequent. It seems to be associated with the use of multiple anesthetic agents in the same patient. Hypercapnia may be responsible in some instances.

The prognosis is dependent upon the interval between the onset of cardiac arrest and the institution of adequate therapy. Without previous planning and prior organization, this interval is rarely short enough to save the life of the patient.

(D.W.B.) 8700 West Wisconsin Avenue.

REFERENCES

1. Stephenson, H. E., Jr., Reid, L. C., and Hinton, J. W.: Some common denominators in 1200 cases of cardiac arrest, Ann. Surg. 137:731–744 (May) 1953.
2. Ament, R., Papper, E. M., and Rovenstine, E. A.: Cardiac arrest during anesthesia; review of cases, Ann. Surg. 134:220–227 (Aug.) 1951.
3. Johnson, J., and Kirby, C. K.: Prevention and treatment of cardiac arrest, J.A.M.A. 154:291–294 (Jan. 23) 1954.
4. Sadove, M. S., Wyant, G. M., Julian, O. C., and Dye, W. S.: Cardiac arrest, Am. Surgeon 20:5–15 (Jan.) 1954.
5. Lahey, F. H., and Ruzicka, E. R.: Experiences with cardiac arrest, Surg., Gynec. & Obst. 90:108–118 (Jan.) 1950.
6. Glenn, F.: Cardiac arrest during surgery, Ann. Surg. 137:920–924 (June) 1953.
7. Problem for anesthetist and surgeon—cardiac arrest (editorial), Surg., Gynec. & Obst. 97: 111–112 (July) 1953.
8. Sloan, H. E.: Vagus nerve in cardiac arrest; effect of hypercapnia, hypoxia and asphyxia on reflex inhibition of heart, Surg., Gynec. & Obst. 91: 257–264 (Sept.) 1950.
9. Campbell, G. S.: Hypercapnia—abetting factor in cardiac arrest (editorial), Surgery 33:915–916 (June) 1953.
10. Bellville, J. W., Artusio, J. F., Jr., and Glenn, F.: Electroencephalogram in cardiac arrest, J.A.M.A. 157:508–510 (Feb. 5) 1955.

OTOLARYNGOLOGY MEETING

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from October 1 through 7, 1956. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose, and throat.

Interested physicians should write to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: E. S. Olson, M. D.

Report of a Case*

E. A. S., a 57-year-old white female, was admitted to St. Luke's Hospital on Nov. 7, 1954, and expired on Dec. 3, 1954. She had had stomach trouble for several months with belching of gas and vomiting of bile. It was estimated that she had lost 90 pounds in the last year and about 50 pounds in the last six months. One week before entering the hospital she began to have severe pain in the abdomen and also some vomiting, and was unable to keep even liquid in her stomach. She continued this way for the entire week prior to her admission. The condition on admission was very poor.

A physical examination showed the pupils to be equal and reacted to light and accomodation. The tongue was very dry. The teeth were in fair condition. The neck showed no evidence of palpable tumor. Examination of the lungs showed rapid and shallow respirations. There were no definite rales or dullness. There was no enlargement of the heart. The blood pressure was 98/70. There were no murmurs. There were no palpable glands or tumors in the breasts. The abdomen was tender. There was a palpable mass in the epigastrium in the region of the stomach. The liver was enlarged 2 to 3 fingers below the costal margin, and was tender. There was no definite evidence of jaundice. Examination of the lower portion of the abdomen showed no tumors or other abnormalities. A pelvic examination revealed the uterus to be slightly enlarged. The cervix was normal to palpation. The rectal examination was negative. A neurological examination showed the reflexes to be normal.

Laboratory Data

The prothrombin time on November 8 was 13 seconds, or 70%. The nonprotein nitrogen was 72 on admission, 235 on November 11, and down to 102 on December 1. The creatinine was 5.2 on November 8, and was down to 2.2 on November 26. The blood sugar on admission was 167, and on November 9 was 176. The blood chlorides varied between 85 and 90 mEq. per liter. The carbon dioxide on November 11 was 32 mEq. per liter, and it was also within normal limits on November 26. The potassium was 3.4 mEq. per liter on November 11, and on December 1 it was 4.6 mEq. per liter. The total proteins were 5.6 on December 1; the albumin was 1.8, the globulin 3.8. The sodium was 140 mEq. per liter on November 11, and on November 26 it was 134 mEq. per liter. Urinalysis on four different occasions showed a trace of albumin. The sugar varied between 2 plus and a trace. The acetone was negative. The white blood cells varied between 2 and 20 per high power field. The red blood cell count was 5,000,000 on admission and was 4,790,000 on November 24. The white blood cell count varied between 14,450 and 28,100. The segmented cells varied between 78 and 85%, and the bands varied between 3 and 6%. The sedimentation rate was 10 mm. in 60 minutes and the hematocrit was 53 mm. on admission. The amylase was 77 units (normal, 20 to 40).

X-ray

On November 20, a gastrointestinal series was performed. Fluoroscopic examination of the chest was normal. The barium meal showed the stomach to be somewhat dilated with a considerable amount of fluid present. Only a small quantity of barium was given. No disease was detected, except for a small diverticulum in the fundus. The duodenum filled with considerable difficulty. A diverticulum was noted in the descending segment. It had a smooth contour and was not considered diseased. There was dilatation of the duodenum, but barium passed through without any particular difficulty. There was dilatation of the jejunum. The loops of the jejunum occupied the left side of the abdomen and extended into the pelvis. Examination made at intervals showed dilated loops confined to the areas noted above, with a

*From St. Luke's Memorial Hospital, Racine.

point of partial obstruction apparently present in the pelvis. After 24 hours some of the material passed into the distal small bowel, and the terminal ileum and the cecum were outlined.

Progress in Hospital

The patient collapsed while in the x-ray room on November 9. On November 10, the blood pressure was 130/70. The patient was mentally confused. On November 10 she went into a mild shock after eating dinner. She retained her food but became weak when she attempted to expel flatus. The general condition remained poor. The skin was dry. The patient remained lethargic. On November 14, she appeared more alert, with the pulse stronger. The tongue remained dry. On November 17 the mass in the epigastrium appeared smaller. On November 18 the patient vomited profusely; the vomitus was foul smelling. On November 21 she was very weak. On November 22 the pulse was very weak, and the general condition was considered poor. The patient was never considered to be in condition for an exploratory laparotomy. On November 26 she had a large emesis. An enema produced good results. She remained lethargic, irrational, and somewhat confused; she also appeared toxic. There was poor tissue turgor. The patient was still in a critical condition.

The temperature was normal the first two days. Then it varied between normal and 101 F. until November 21, when it became normal and remained so until November 27. Then it went up to 100.3 F. for two days. Then it remained normal until December 3, when it increased to 102.4 F.

Q. Dr. W. J. Little: Was there anything known about possible diabetes in this case? **A. Dr. R. J. Schacht:** No, there were no further data. I only saw the patient in a critical state just before she was admitted to the hospital.

Q. Doctor Little: Was there anything in the menstrual history that was of significance? **A. Doctor Schacht:** There was no abnormal menstrual history obtained.

Q. Doctor Little: Was the patient known to have any gallbladder trouble? **A. Doctor Schacht:** There was no evidence that a physician had diagnosed the problem.

Q. Doctor Little: How was the pain described? **A. Doctor Schacht:** The pain was present all over on the right side and in the back. It was present more or less diffusely.

Q. Doctor Little: Was the mass attached to the liver? **A. Doctor Schacht:** The mass was located in the region of the stomach, and attachment to the liver could not be definitely determined.

Q. Doctor Little: Was the mass hard, and was there any pulsation? **A. Doctor Schacht:** The mass was moderately firm. There were no pulsations determined.

Q. Doctor Little: Were there bowel sounds present? **A. Doctor Schacht:** The patient passed gas through the rectum. There was very little distention, and it was never alarming. The Wangensteen tube was used periodically, depending upon the course of the distention and the vomiting. The patient could frequently take soft foods.

Discussion

Doctor Little: This patient had been having episodes of vomiting for several months to one year. There was a mass palpated in the epigastrium. The liver was enlarged and tender. The patient had azotemia. She was dehydrated at the time of the hospital admission; this was considered secondary to the obstruction of the upper portion of the gastrointestinal tract.

Intestinal obstruction should be considered, first that of the adynamic type. Renal azotemia could present a similar picture. However, this could be fairly well ruled out as a primary factor as neither the nonprotein nitrogen nor the blood pressure was materially elevated when the patient entered the hospital. The possibility of a gallbladder condition with acute pancreatitis must be considered. The pain and clinical picture would not be inconsistent with such a diagnosis. The relatively normal amylase would tend to rule out an acute pancreatitis, but the amylase may not be too significant in such a protracted clinical picture. Addison's disease may present an acute condition of this type. However, there was a low potassium and the blood sugar was high. Possibility of diabetic acidosis must be considered; but this condition was ruled out by a carbon dioxide determination, and the blood sugars were not very high. A vascular occlusion of the mesenteric vessels must be thought of, but the long history would not be consistent with this finding. Hepatitis might be considered, along with a cirrhosis. The icteric index was slightly elevated. The prothrombin time was 13 seconds or 70% when the patient

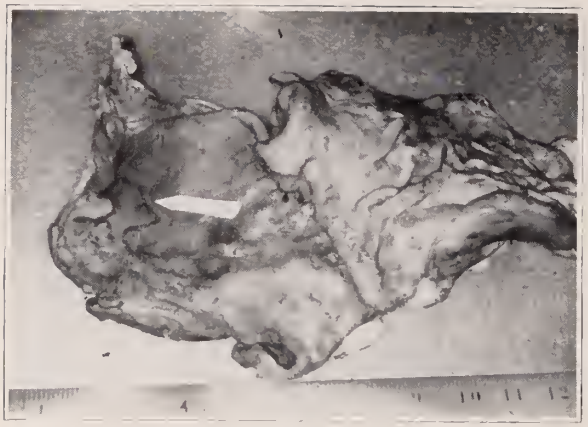

Fig. 1—Site in the duodenum where the stone penetrated into the lumen.

Fig. 2—Gallstone which obstructed the jejunum. There was perforation at the site of the obstruction.

entered the hospital. Further studies of the liver condition might have been helpful.

A second category to consider would be organic obstruction. This would include adhesions, but there is no history of previous operation. There could be peritoneal involvement, secondary to tumors in the ovary and the uterus. The uterus was only moderately enlarged. A carcinoma of the large bowel that had extended to the small bowel is a possibility. Even a carcinoma of the stomach with drop metastases would have to be considered. Also, we should think of an inflammatory mass in the pelvis such as an abscess following diverticulitis.

A third category for consideration would be intraluminal obstruction. A tumor of the small bowel would be exceedingly rare. A gallstone in the small bowel must be considered, but it would have to be of the nonopaque type. An intussusception and a volvulus are other considerations. It is difficult to reach a definite conclusion. With the data available at the present time, I favor metastasis from the stomach. Carcinomas of the colon, gallbladder, and ovary would also have to be considered.

Gross and Microscopic Pathology

Dr. E. S. Olson: The essential postmortem findings were as follows: The body showed average nourishment in spite of the great loss of weight. The patient was quite obese prior to her present illness. Examination of the contents of the chest, including the pericardial sac, lungs, pleural spaces, and heart was not remarkable, except for the finding of a moderate amount of mucus in the bronchi.

Examination of the abdomen showed the peritoneum to be dull and lusterless. There was about 500 cc. of serous turbid fluid with a fecal odor within the peritoneal cavity. The stomach was distended. There was a perforation of the duodenum located 7 cm. from the pyloric ring that averaged 1 to 1.5 cm. in dimension. The perforated area had an irregular serpiginous contour. This area was in direct contact with the gallbladder by means of a sinus tract. There was a diverticulum located 11 cm. from the pyloric ring. It extended 8 mm. beneath the mucosa. The lumen was small. The proximal 4 feet of the jejunum were dilated. The wall was edematous. The distal portion of the dilated jejunum was located in the pelvis. The lumen contained a gallstone at this site that measured 6 by 3 by 2 cm. The stone was of the mixed variety. The central portion was composed of cholesterin that later became surrounded by a thin layer of calcium bilirubinate. The jejunum at the site of the stone had perforated. There was a large irregular area of necrosis where the bowel was perforated. There were many adhesions present with beginning abscess formation. The small bowel distal to the stone was collapsed. There was a moderate amount of liquid fecal material present within the cecum. The hepatic

flexure was firmly attached to the gallbladder bed.

The liver weighed 1,660 gm. The gallbladder was a fibrotic mass. The common bile duct could be traced to the cystic duct. There were cholesterin crystals and calcium bilirubinate in the area of the cystic duct and in the lumen of the gallbladder. There were a large number of adhesions about the gallbladder. There were no stones in the common duct. There was fibrosis of the liver tissue about the gallbladder. The spleen, adrenals, and kidneys were not remarkable.

The anatomical diagnoses were: 1. cholecystitis, chronic with perforation into the duodenum; 2. cholelithiasis; 3. obstruction, jejunum, partial, secondary to a gallstone; 4. peritonitis, acute; 5. paralytic ileus involving the jejunum and stomach.

Summary

This patient had a large, solitary gallstone that penetrated through the duodenum and migrated to the pelvis in the jejunum. The stone became incarcerated in the pelvis and perforated the bowel, which resulted in peritonitis. Many adhesions were present between the stomach, hepatic flexure of the colon, and the liver bed, as well as between the liver and the diaphragm. The gallbladder was a fibrous mass with some cholesterin crystals, as well as calcium bilirubinate, present.

Q. Dr. L. E. Jones: Did the stone enter the duodenum through the diverticulum? **A. Doctor Olson:** The diverticulum was easily demonstrated at the time of the postmortem examination. It was not associated with the gallstone or the gallbladder bed.

Doctor Jones: The gallstone was x-rayed after it was removed from the body; serial pictures were taken, varying the kilovoltage from 30 to 60. It was shown that there was no radiopaque calcification present. In the ordinary kilovoltage employed for abdominal radiography this gallstone could not be visualized. Examination of the gastrointestinal films after the findings are known show a thin line of opaque density that extends from the proximal portion of the duodenum toward the gallbladder bed. This, most likely, is the tract of the gallstone as it perforated into the duodenum.

Conclusion

Doctor Olson: We wish to point out that Doctor Schacht offered the diagnosis as found at the postmortem examination before he saw the final results. The patient never was in condition for an exploratory laparotomy.

In conclusion, the clinical features in this case were suggestive or compatible with a gallstone in the small intestine; namely, the intermittent type of obstruction. This is due to the fact that the bowel proximal to the stone would dilate, and the material in the proximal portion would then be forced into the distal aspect of the bowel about the stone. The gallstone presented a ball-valve type of obstruction. The patient was in critical condition during her entire stay in the hospital. If this stone had perforated into the large bowel, we would expect more liver involvement. It is possible that the stone would have passed if this were true. The contents of the large bowel would result in a cholangitis through the sinus tract.

JOHN HARRIS MEMORIAL LECTURE FUND

A memorial fund has been established in memory of John Harris, M. D., late professor and head of the department of obstetrics and gynecology at the University of Wisconsin. The fund will be used to provide for an annual lecture at the University in the field of obstetrics and gynecology by some nationally known specialist in the field.

Contributions to the fund should be directed to John Z. Bowers, M. D., Dean, University of Wisconsin Medical School.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

An Appeal for Objectivity in Treatment

One of the author's associates recently remarked to a class of medical students that it was not uncommon to find the physician of the past prescribing treatment for the benefit he himself might derive therefrom. I wonder if a complete relegation of this practice to the past isn't, in a sense, a bit of wishful thinking. How often does the practitioner of medicine in our present scientific era prescribe a drug which has received endorsement primarily on the basis of a subjective rather than an objective evaluation? How frequently does he fail to exercise critical consideration of the claims made for a form of therapy to ensure that a proposed method at least produces some clearly defined results?

It is admittedly difficult to evaluate data which are obtained from the clinical application of a new drug, especially in situations where the etiology is unknown and the treatment is of necessity symptomatic. An example to illustrate this point relates to the therapy of hypertension. The literature on this subject is replete with studies which contain so many fallacies as to make them almost valueless. Critical evaluations of some of the errors which have resulted in the enthusiastic endorsement of a number of drugs for the treatment of hypertension have been made by several investigators. Certain of their conclusions would be generally applicable.

In evaluating the effectiveness of therapy in hypertension, it is imperative that the marked fluctuations in blood pressure and symptoms be carefully considered. Yet in so many reports one finds that these are treated as constant factors, alterable only by the treatment under examination. Ayman[1] effectively pointed out the errors in drawing conclusions on the basis of symptomatic changes. He carefully analyzed 35 articles published between 1912 and 1929, in which several forms of unrelated therapy employed for the treatment of hypertension were discussed, and found that complete failure, assessed on the basis of changes in blood pressure or relief of symptoms, was seldom encountered. The immediate question arises as to the reason, or reasons, for the effectiveness of such a variety of different approaches; *e.g.*, treatment with mistletoe, watermelon extract, radium water, thiocyanate. Ayman has given a partial answer in the above-mentioned and subsequent papers,[2, 3] and other authors[4-7] have reemphasized and added to Ayman's conclusions. The degree of enthusiasm with which the physician undertakes a new therapeutic regimen will greatly affect the degree of subjective response obtained. In an alarming number of reports there is a relative lack of careful scientific control. Preliminary observations often are conducted for too short a time; too small a number of patients is employed to allow the acquisition of significant results. Very often the period of treatment is short, perhaps a few weeks, in spite of the fact that long-term studies have invariably demonstrated that initial results may be misleading. Evelyn[5] noted that the inadequacy of controls was particularly evident in the studies on sympathectomized patients at a Massachusetts hospital. The failure to control as many subconscious factors as possible is most important to consider in evaluating antihypertensive (and other) therapy. Differences in attitudes of the investigators may not only influence opinion (clinical impression), but actually affect the outcome of the treatment in the patient. Only one way of overcoming this difficulty exists at the present time and this is by use of the "double blind" method, in which neither the patient nor the physician is informed of the nature of the treatment.

In spite of the number of fine papers which have dealt with the pitfalls inherent in the determination of the effectiveness of an antihypertensive agent, we continue to see a repetition of past mistakes. Waldron *et al.*,[8] in their recently reported studies with

Rauwolfia serpentina, protoveratrine, and phenoxybenzamine (Dibenzyline), failed to use the "double blind" procedure and hence adequately control the subjective factor. Waldman[9] erred in a similar fashion and did not provide evidence in his paper to indicate that he had employed sufficiently long control periods to establish true baseline data. Unfortunately, there is no dearth of similarly conducted studies, and like examples could be obtained from the literature which deals with the treatment of other diseases.

At one time the evaluation of therapeutic effects by clinical impression was justifiable. However, with our present state of knowledge in connection with experimental design, continuation of such a practice is deplorable. The appeal for careful examination of claims for "cures" has gone to the public,[10] but the layman ultimately has to depend on his physician for advice in such matters. Therefore, is it expecting too much to ask him, the family doctor, to acquaint himself with the errors so commonly made in the clinical evaluation of new drugs and to determine whether or not a truly scientific, objective approach has been made to the problem? It might be well for him to keep uppermost in his mind that oft-quoted question of Dr. Anton J. Carlson, "What is the evidence?"—F. E. SHIDEMAN, M. D.

REFERENCES

1. Ayman, D.: Evaluation of therapeutic results in essential hypertension; interpretation of symptomatic relief, J.A.M.A. 95:246–249 (July 26) 1930.
2. Ayman, D.: Evaluation of therapeutic results in essential hypertension; interpretation of blood pressure reductions, J.A.M.A. 96:2091–2094 (June 20) 1931.
3. Ayman, D.: Critique of reports of surgical and dietary therapy in hypertension, J.A.M.A. 141: 974–977 (Dec. 3) 1949.
4. Jonas, A. D.: Variability of blood pressure readings, New York State J. Med. 50:1249–1251 (May 15) 1950.
5. Evelyn, K. A.: Long-term study of natural history of essential hypertension, Ann. Int. Med. 33: 629–635 (Sept.) 1950.
6. Watkin, D. M., Froeb, H. F., Hatch, F. T., and Gutman, A. B.: Effects of diet in essential hypertension, Am. J. Med. 9:428–440 (Oct.) 1950.
7. Blainey, J. D.: Hexamethonium compounds in treatment of hypertension, Lancet 1:993–996 (May 17) 1952.
8. Waldron, J. M., Reinhardt, D. J., III, Jenson, W. K., and Goldstein, F.: Treatment of diastolic hypertension with fixed combination of hypotensive drugs, Am. J. M. Sc. 230:551–557 (Nov.) 1955.
9. Waldman, S., and Pelner, L.: Treatment of ambulatory hypertensive patient with pentolinium tartrate, Am. J. M. Sc. 231:140–150 (Feb.) 1956.
10. Dukelow, D. A.: Be sure about "cures." *The Milwaukee Journal*, May 6, 1956.

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Roosevelt in New York City on Oct. 18, 19, and 20, 1956.

The course will be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, professor of surgery, University of Minnesota Medical School, who will serve as surgical co-ordinator, and Dr. I. Snapper, director of medical education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator.

The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will cover, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, Department P. G., 33 West 60th Street, New York 23, N. Y.

A Quarter Century of Water Supply Safety

As It Looks to Your State Board of Health

JUST a little more than a quarter century of time has passed since Wisconsin had its last serious outbreaks of typhoid fever that were traceable to contamination of water supplies. The three epidemics in 1929 were the last serious outbreaks of record. They caused 140 cases of typhoid fever with 16 deaths. More than two-fifths of the total cases of typhoid fever in that year were due to these outbreaks.

Two of the three epidemics involved public water supplies, while the other involved a private supply serving a large number of seasonal agricultural workers. The latter outbreak and one of the former resulted from contamination of the wells serving as the sources of supply, while the third resulted from contamination of the distribution system through a cross connection with a river water supply for boilers at an industrial plant. The wells involved in these occurrences drew part or all of the water from creviced limestone formations.

The primary causes of these outbreaks; namely, a cross connection with a polluted source and use of water from creviced limestone formations without disinfection, had been recognized as hazards to public health; and efforts were being made to eliminate or control them in all water supply systems. These outbreaks thus lent emphasis to the need for a continuing program and stronger controls in areas of weakness, they brought about more rigid regulations on cross connections, and they made it easier for public health workers to obtain recognition and correction of similar and other hazards to water supply safety.

Since 1929 no case of typhoid fever has been traced to a public water supply source. A few small outbreaks and a number of isolated cases of typhoid fever have been attributed to the use of contaminated private wells. Such cases, however, are continuing to decline in number also as evidenced by the following statistics covering the first and last five-year periods in the last quarter century.

		Total Number	Average Per Year
Typhoid fever cases	1931–1935	711	142.2
	1951–1955	78	15.6
Typhoid fever deaths	1931–1935	86	17.2
	1951–1955	3	0.6

It should be noted that the reduction in incidence of typhoid fever disclosed by these statistics is not due solely to water supply improvement but reflects all environmental and carrier controls.

During the past quarter century much improvement to water supplies, both public and private, has been brought about. Many sources of ground water supply serving public systems have been replaced or reconstructed so as to minimize the danger of contamination by sewage. Public surface water supplies in all but one instance have been provided with purification plants, while many sewage treatment plants have been installed to reduce pollution of the surface waters.

An effective program on cross connection elimination has materially decreased the hazard from this standpoint. Registration of well drillers and pump installers, the development of adequate regulations, the manufacture of improved water supply equipment, and a continuing educational program have brought about substantial benefits to the users of private water supplies. All these improvements are reflected in the aforementioned lower incidence of typhoid fever. They would also be reflected in the statistics covering other water-borne diseases such as dysentery and gastroenteritis.

There is a tendency to believe that, because of the present-day low incidence of typhoid fever, controls can be relaxed. Actually, however, tighter controls would be justifiable because of the lowered immunity of our people to typhoid fever and other water-borne diseases. The recent outbreak of typhoid fever in Germany, over 600 cases, demonstrates this susceptibility of the people to water-borne infection. The greater incidence of infectious hepatitis, which may be water-borne, also should be kept in mind.

No discussion involving typhoid fever cases in Wisconsin would be complete at this time without mention of the increased number of sporadic, widely disseminated cases that have occurred in this and adjoining states since about the first of the year. These cases are under intensive study by the State Board of Health and the United States Public

Health Service. Although the actual source of the infection has not been determined, sufficient data is at hand to preclude transmission by water. These cases, however, again emphasize need of control in all fields.

We can be justly proud of the past quarter century of water supply safety; keeping the next 25 years even more safe is a challenge for all of us.—O. J. MUEGGE, *State Sanitary Engineer.*

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1956, the March of Medicine began its eleventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	12:15 p.m.
WHSA	Brule	Friday	10:30 a.m
WHKW	Chilton	Friday	10:30 a.m
WCHF	Chippewa Falls	Saturday	9:45 a.m.
WHWC	Colfax	Friday	10:30 a.m
WHAD	Delafield	Friday	10:30 a.m
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Friday	10:30 a.m
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	5:00 p.m
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	1:00 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Friday	10:30 a.m
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:45 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Friday	10:30 a.m
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	11:00 a.m.
WBKV	West Bend	Saturday	11:15 a.m.
WHLA	West Salem	Friday	10:30 a.m

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A Library for Medicine

One of the world's most valuable collections of medical documents is in danger of destruction or deterioration. The famed Armed Forces Medical Library in Washington, D. C., housed in dozens of temporary buildings, inadequately maintained and poorly staffed for proper use, may be lost to the physicians of this nation and the entire world unless appropriate steps are taken immediately to preserve the collection.

At least one bill, S. 3430, introduced by Senator Hill of Alabama and Senator Kennedy of Massachusetts, seeks to create a national library of medicine which would take over the Armed Forces Medical Library, its collections, records, and equipment. Currently, the library is under the Department of Defense, where it does not have complete legislative authorization and is forced to compete with the military departments for funds.

The A.M.A. has repeatedly called upon Congress for preservation of these vital documents. It is recorded as favoring Bill S. 3430 or any other legislation which would accomplish the same purpose. Now, while hearings are being conducted by the Senate Labor and Welfare Committee, is the time for all physicians to lend their support to the preservation of this notable collection.

A Gratifying Response

One of the most difficult tasks for the Council, the committees, and the staff of the State Medical Society is that of evaluating the success or failure of specific projects and activities. Perhaps no question is asked as often as this one: "What is your opinion of the Annual Meeting?"

Recently the Council asked for a survey of the membership on its reactions to the May, 1956, Annual Meeting. One type of questionnaire went to every physician who attended, another to those who did not. The response was more than gratifying—it was somewhat amazing.

More than 600 of the 1,600 physicians who attended the Annual Meeting took the time to reply. Of these, nearly 250 added personal comments in longhand. Opinions were evenly divided as to preference for refresher courses, general sessions, and specialty sessions. More doctors preferred "live refresher courses" than preferred television. Comments were overwhelmingly favorable to the type of meeting now being conducted under the direction of the Council on Scientific Work. But there were also a number of highly useful and constructive suggestions.

A RESEARCH MILESTONE

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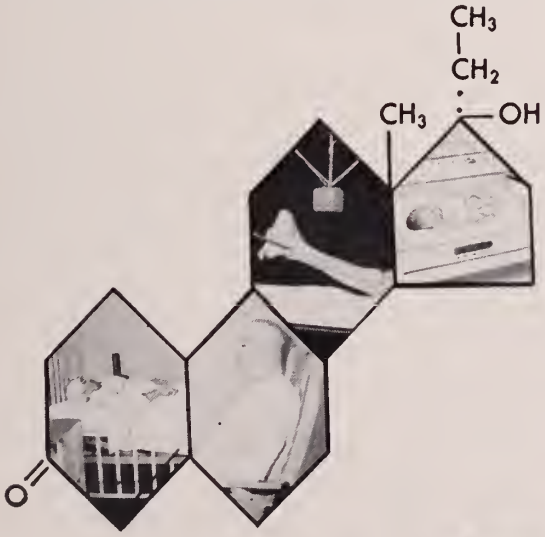

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SEARLE

. . . . THE PRESIDENT'S PAGE . . . .

ONE of the recent meetings I attended has stimulated my thought processes to the point where I feel I must share them with you. You may remember that the House of Delegates in May called upon the Committee on Hospital Relations and the Council on Medical Service to undertake a joint study of hospital–physician relations in Wisconsin. I get around the state quite a great deal, and this is a subject of pretty general concern whenever you talk with physicians in the big cities or the small towns. Now, there are problems. Some of them get started just because the medical staff and the hospital board don't understand each other. Some are local. Some are causing trouble because of national policies quite beyond the ability of the local physicians and hospital administrators to do very much about.

But it has been my experience that a great many controversies that get too hot to handle could have been avoided by the simple expedient of two or three or four people sitting down together in the same room and having a frank and open discussion. I know it is easy to advise and to preach; but when doctors give advice and take a position of leadership, they must be assumed to have a knowledge of the problem—not just a smattering of information and rumor, but facts and well-thought-out opinions.

Both the American Medical Association and the American Hospital Association have agreed that the primary obligation of both physicians and hospitals is to serve the best interest of the patients. Misunderstandings between hospital management and the medical profession arise in part from fears concerning each other. Some of these are reasonable and some unreasonable. By and large, I think there must be understanding on the part of both that each has a certain prerogative in some fields but that they also have a great interdependence in accomplishing their objective.

Doctors are citizens and physicians. As either or both, the doctor has responsibilities which should cause him to rise far above petty argument and disagreement. A little tolerance and understanding and just the plain gentlemanly attitude of "let's get together and talk this over" will go a long way toward achieving ideal relationships between hospitals and physicians.

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Society Proceedings

Fond du Lac

The Fond du Lac County Medical Society and Auxiliary held a joint meeting in Ripon on May 24. Dinner for 56 members and guests was served at the Republican House.

Speaker of the evening was Dr. Laurie A. Fisher of Ripon College. His topic was "On Taking the Doctor's Advice."

Green Lake–Waushara

Eight members of the Green Lake–Waushara County Medical Society met April 19 at the Whiting Hotel, Berlin.

Dr. Fred Geist of Madison presented a paper on neurology, and there was a discussion regarding a polio clinic.

Kenosha

The regular monthly meeting of the Kenosha County Medical Society was held May 17 at the Elks Club in Kenosha. Forty-two members of the society heard Dr. P. R. Campbell, professor of medicine at the University of Illinois, speak on "Application of Cardiac Function Tests."

During the business session the tentative physicians' working agreement with the Kenosha County Public Welfare Department was discussed, and copies of the new fee schedule were given to the members.

Marathon

Approximately 65 physicians attended the dinner meeting of the Marathon County Medical Society May 24. The meeting was held at the Wausau Club, Wausau.

Dr. J. A. Bargen, Rochester, Minnesota, was the guest speaker and discussed "Problems Associated with the Management of Ulcerative Colitis and Other Diarrheal States."

Outagamie

The Outagamie County Medical Society met May 17 at the Elks Club in Appleton. Thirty-six members of the group were present.

Dr. A. M. Olsen, of the Mayo Clinic in Rochester, spoke on "Recent Developments in Inhalation Therapy." A question-and-answer period followed his presentation.

During the business session the society approved a full-page advertisement for the *Appleton Post–Crescent* to congratulate those responsible for the success of the Appleton Community Blood Center, in operation for a year. The ad was to include a group picture of the society members taken at this meeting and copy encouraging donation of blood. The group also approved holding a postgraduate meeting in Appleton in November.

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THE MEDICAL FORUM

CLARIFY DOCTORS' ROLE IN DISABILITY "FREEZE"

New Forms in Use; Need Help of M.D.s

MADISON—When Edward J. Pfeifer, senior supervisor of the State Board of Vocational and Adult Education, Rehabilitation Division, appeared at a recent State Medical Society committee meeting, he said:

"One of the major problems is defining disabilities under Social Security coverage. This refers to persons seeking to preserve their rights to coverage while suffering with disabilities. Under federal law, the disabilities must be proven medically.

"There is a lack of uniformity or knowledge of what constitutes disability. It is true some physicians are unclear in their reports, and some are unwilling to dig deep into an applicant's physical condition. Full evidence is necessary to rule on this freeze. We need complete medical information to do a job.

"This is a matter of interprofessional relations."

HITCHES DEVELOPED

Pfeifer said his division had a backlog of applications because of hitches in processing the applications, and that the matter of clarifying reports was the biggest bottleneck.

He said the form revised in December, 1955, **"is much improved, and experience with its use indicates less need for followup correspondence with physicians regarding specific cases."**

The Bureau of Old Age and Survivors' Insurance provides the form, but a provision of the law places on the applicant responsibility for securing medical evidence in support of his allegation that he is under a disability.

REQUIREMENTS LISTED

Under the freeze, no cash benefits are paid. To be eligible, *an individual must have been continuously disabled for six months, and at the time of application, must be suffering from an impairment that makes it impossible for him to engage in a gainful occupation.* Such an impairment must be one of long-continued and indefinite duration or one that is likely to result in death.

By Act of Congress, the determination of disability is made by the State. In Wisconsin, the **State Department of Public Welfare** and the **State Board of Vocational and Adult Education, Rehabilitation Division,** were designed as the agencies to do this work.

The Welfare agency adjudicates cases involving visual impairment or blindness, and the receipt of public assistance. Pfeifer's division passes on all others except where disability began before Jan. 1, 1952.

To do the job effectively, the agencies employ registered physicians to serve as medical consultants in the making of disability freeze determinations.

These determinations represent claims against the Social Security Trust Fund. *Such claims must be medically determinable and must be substantiated not only by the diagnosis but also by the pertinent clinical findings upon which the diagnosis is based.*

(Continued on page 758)

AMA Trustees Set Up Policy for Evaluating Foreign Med Grads

CHICAGO—A long-sought policy for evaluating foreign medical school graduates and planning administration of a program to govern this policy has been approved by the AMA Board of Trustees.

DESIGNED TO CLARIFY

The proposed program is designed to clarify two major qualifications of each graduate who wishes to come to the United States as an intern or resident or in any other position involving medical care of the American public:

1. The medical credentials of a foreign-trained physician must indicate clearly that he was graduated from a bona-fide medical school.

2. By examination, a foreign-trained graduate must demonstrate he has medical knowledge equivalent to that demanded of graduates of schools in the United States.

NOT AUTOMATIC

In Wisconsin, the foreign-trained medical student must pass tests required by the State Board of Medical Examiners. The program approved by the AMA Board of Trustees does *not* automatically qualify a student to practice in Wisconsin.

Asks Check on Registration of Physical Therapists

MADISON — Medical clinic and hospital officials are being asked by the State Board of Medical Examiners to check the qualifications of the physical therapists on their staffs.

Wisconsin law requires that the therapists hold a state certificate in physical therapy and be registered with the Board.

Apparent misunderstandings in the past year have resulted in restating statutes relating to the therapists, the Board said. If the therapists are not registered, they are practicing unlawfully and are subject to court orders calling for their dismissal, the Board said.

275 APPROVED

Approximately 275 physical therapists now practicing in Wisconsin were properly registered and certified, following Board examinations.

Chapter 147.185 of Wisconsin Statutes reads:

(b) No person shall practice or hold himself out as authorized to practice physical therapy, nor shall any person designate himself as a physical therapist, physiotherapist, physical therapy technician, or use the initial "P.T.," "P.T.T.," or "R.P.T." or any other letters, words, abbreviations or insignia indicating that he is a physical therapist without certificate of registration issued by the Board of Medical Examiners . . ."

SCHEDULE TWELVE CIRCUIT TEACHING PROGRAMS

MADISON—A series of 12 Circuit Teaching programs, to be held this fall and next winter, will be more practical and valuable than ever before, the Council on Scientific Work believes.

Development of afternoon clinical sessions, held in selected hospitals, with the use of patients and case studies, was cited as a practical means of making the popular teaching programs of more direct value to the practitioners who attend.

Dr. M. G. Rice, of Stevens Point, Council chairman, said:

"In planning this year's program, it was felt that most direct value could be derived from a combination of clinical teaching and informal lectures. Arrangements are being made through local committees to present interesting material in the areas to be covered and have the visiting faculty use the clinical material for teaching purposes."

CREDIT AVAILABLE

On the basis of previous clinic programs, the schedule was worked out to provide a full afternoon and evening of instruction, with dinner included in the $6 registration fee. *Physicians who attend are requested to attend both sessions, as the meetings will be correlated, and those who attend both sessions will receive credit for Academy of General Practice membership requirements.*

As in past years, the programs are provided as a service to members of the State Medical Society. Cooperating agencies are the State Board of Health, the medical schools of the University of Wisconsin and Marquette, the Wisconsin Academy of General Practice, the Wisconsin Heart Association, Wisconsin Anti-Tuberculosis Association and the Wisconsin Division of the American Cancer Society.

In order to assist with program planning, those who wish to attend these teaching programs are requested to make advance reservations by use of the accompanying coupon. All checks should be made payable to the State Medical Society of Wisconsin, and the reservation should indicate clearly which clinics will be covered by the reservation.

SCHEDULE AND FACULTY OF PROGRAMS

SEPTEMBER 11: St. Francis Hospital, La Crosse
SEPTEMBER 12: Sacred Heart Hospital, Eau Claire
SEPTEMBER 13: St. Mary's Hospital, Superior

Faculty: Dr. John Z. Bowers, Madison, arthritis; Dr. George Barnes, Iowa City, Ia., pediatrics; Dr. James Conley, Milwaukee, surgery, and Dr. Donald Ruch, Milwaukee, dermatology.

OCTOBER 9: Bellin Hospital, Green Bay
OCTOBER 10: St. Joseph's–Lloyd Hospital, Menominee, Mich.
OCTOBER 11: St. Mary's Hospital, Wausau

Faculty: Dr. Gordon Marlow, Madison, proctology; Dr. Lamont Schweiger, Milwaukee, cardiology; Dr. Martin Seifert, Chicago, internal medicine. (Obstetrician to be selected).

NOVEMBER 27: Memorial Hospital, Lancaster
NOVEMBER 28: Mercy Hospital, Janesville
NOVEMBER 29: St. Elizabeth's Hospital, Appleton

Faculty: Dr. Thomas Geppert, Madison, pediatrics; Dr. Sture A. M. Johnson, Madison, dermatology; Dr. Wilson Weisel, Milwaukee, chest surgery. (Obstetrician to be selected).

JANUARY 15: St. Mary's Hospital, Madison
JANUARY 16: Mercy Hospital (nurses' dormitory) Oshkosh
JANUARY 17: St. Nicholas Hospital, Sheboygan

Faculty: Dr. John S. Hirschboeck, Milwaukee, internal medicine; Dr. Ralph Reis, Chicago, obstetrics; Dr. Howard Lee, Milwaukee, allergy, and Dr. James Stack, Chicago, orthopedics.

RESERVATION SHEET

Detach this coupon and mail to State Medical Society, P. O. Box 1109, Madison, Wis.

Please make your check of $6 payable to the State Medical Society.

The registration fee, which includes dinner, is $6 per clinic. No reduced fee for attendance at portion of program only.

Check the Clinics You Will Attend:

SEPT. 11: LA CROSSE _____
SEPT. 12: EAU CLAIRE _____
SEPT. 13: SUPERIOR _____

OCT. 10: MENOMINEE, MICH.
OCT. 9: GREEN BAY _____
OCT. 11: WAUSAU _____

NOV. 27: LANCASTER _____
NOV. 28: JANESVILLE _____
NOV. 29: APPLETON _____

JAN. 15: MADISON _____
JAN. 16: OSHKOSH _____
JAN. 17: SHEBOYGAN _____

Name _____
(print, please)

Street Address _____

City _____

STATE HEALTH COUNCIL MEETING A BIG SUCCESS

Pin-Point Problems; Study Community Needs and Programs

MADISON—The Wisconsin Public Health Council's "mighty challenge for 1956" involves fluoridation, health careers, safety, mental health and health departments.

These health problems received the spotlight at the Council's second annual meeting in Madison June 5. More than 160 persons from all over Wisconsin attended, almost twice as many as attended the initial gathering a year ago.

FEATURE EVENT

The portrayal of the health problems by means of slides and narration and a panel of experts was one of the highlights of the meeting.

Here are some of the vital points stressed by the panelists:

Fluoridation: *"Where fluoridation is defeated, it is by fear propaganda, based on the contention that pure sodium fluoride is a poison. Actually, it would be impossible to load a fluoridating mechanism with enough of the chemical to poison humans. To combat the propaganda, we must do a great job of education."*—James D. Kelly, D.D.S., La Crosse.

Safety: *"Public education is needed, is vital, to reduce home accidents. The Council must lead the fight for safety."*—Lee W. Schwenn, Madison Health Department.

Health Careers: "There is need to begin at the elementary and junior high school level to interest children in entering the health professions when they grow to adulthood."—Warren Southworth, University of Wisconsin.

"MUCH TO BE DONE"

Mental Health: "There is great need for preventive measures in the mental health field. Here we can and must do much. I urge increased guidance facilities and psychiatric personnel." The Rev. Max D. Gaebler, Madison.

Health Departments: *"Health departments must cooperate, work with other groups to inform people of the value of fluoridation and other major health matters."* E. E. Bertolaet, M.D., Kenosha Health Commissioner.

Dr. Mason

Six others participated in a panel on the subject "Meeting Needs Through Local Action, An Idea Exchange." They were:

A. F. Wileden, of the University of Wisconsin; **Esther Larson,** R.N., DePere; **Bernard Solochek,** Milwaukee; **E. Dorothy Wahlstrom,** Hammond; **Monte Pelton,** La Crosse and Mrs. **Monroe Tubbs** of Cross Plains.

R. A. Mason, D.D.S., Milwaukee, was chosen Council president for the next two years. C. W. Kammeier, Milwaukee, executive secretary of the Wisconsin Anti-Tuberculosis Association, was elected second vice president.

The following were named to the Board of Directors:

Edith Bangham, Madison, the immediate past-president; C. K. Kincaid, M.D., Madison; Palmer Daugs, Lake Mills; Mrs. August J. Baumann, Cottage Grove and M. W. Stuessy, M.D., of Brodhead.

The Dane County Association of Health Councils, the Fond du Lac School Health Council and Radio Station WDOR, Sturgeon Bay, received top awards in health achievement during the past year. Receiving honorable mention were the Muskego Township Health Council, Waukesha County; the Eau Claire Coordinating Council; the Outagamie County Health Council; WMTV, Madison, and WISN and WISN-TV, Milwaukee.

Persons attending the annual meeting also watched a film, *"Community Health in Action,"* which pin-pointed major problems and programs. The 30-minute, sound and color picture is available from the Council, Box 1109, Madison, or the State Board of Health Film Library in Madison.

U.W. to Hold Meeting on Health Problems

MADISON—Dr. W. W. Bauer, Chicago, director of the AMA Bureau of Health Education, will be the keynote speaker at a Univ. of Wis. Conference on Practical Ways of Handling Guidance and Health Problems, July 23–25.

Dr. Bauer will speak on *"The Implication of Technological Change for Health Education."*

Other physicians taking active roles in the sessions will be Dr. **Allan Filek** and Dr. **Leland K. Reeck,** of Madison; Dr. **Keith Keane,** Sheboygan and Dr. **Theodore Hill** of South Bend, Ind.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

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MILWAUKEE WISCONSIN

Urge Use of Color TV at 1957 Meeting

MADISON—It is altogether likely that color television will be a prominent part of the 1957 Annual Meeting of the State Medical Society in Milwaukee.

The Council on Scientific Work, at a recent meeting, approved a proposal to cooperate with the Wisconsin Surgical Society, the Wisconsin Society of Internal Medicine and the staff of Milwaukee County Hospital, where the telecasts would be presented, to utilize the TV medium next year for the first time in Wisconsin.

The proposal must be sanctioned by the General Council before the Council on Scientific Work can proceed with plans. The two groups will meet in late July.

There was general agreement that the 1957 session will follow the same pattern used this year, with General Practice Day opening the meeting, and specialty programs the second and third day.

Consideration also was given a plan to arrange special programs for allergists, pediatricians and gastro-enterologists next May.

NAME CHAIRMEN

Dr. Maurice Rice, Stevens Point, was named chairman of the Council on Scientific Work for the ensuing year. Dr. **L. G. Kindschi,** Monroe, was named general program chairman for the 1957 Annual Meeting, and **Dr. Kenneth Lemmer,** Madison, assistant. **Dr. M. F. Huth,** of Baraboo, was selected to serve as chairman of the scientific exhibits, and **Dr. M. C. F. Lindert,** Milwaukee, as chairman of the host committee.

A suggestion to allot up to $100 to a maximum of five committees each year to aid in developing Annual Meeting exhibits met with favor. It was agreed that committees would make application to the Council and forward plans in time to include them in the list of exhibits.

Dr. Lemmer said he thought it would be a very desirable plan to make awards for meritorious scientific exhibits, with advantages being encouragement of better exhibits and increased interest. It was recommended that the General Council approve the development of awards, with the Council on Scientific Work assisting in classification and developing scrolls for outstanding exhibits. A judging system would be devised, possibly with the assistance of the outside speakers.

The Council on Scientific Work voted to enlist the aid of the American Medical Association legal office in developing a medical-legal program at the next Annual Meeting in Milwaukee. If the General Council approves, it was suggested that an outstanding speaker be invited to participate.

Prepaid Plan Commission Discusses Wide Range of Business, Names Officers

CHICAGO—Re-election of three officers of the **Commission on Prepaid Plans** was confirmed at a meeting in Chicago, June 9.

The Commission met just prior to the Annual Meeting of the A.M.A.

Dr. Robert Krohn, Black River Falls, was renamed vice chairman; **Dr. N. A. Hill,** Madison, treasurer of Wisconsin Physicians Service, and **Dr. John T. Sprague,** Madison, assistant treasurer.

Earlier, the General Council had reappointed *Dr. E. M. Dessloch,* Prairie du Chien, as Commission chairman; *C. H. Crownhart,* secretary-general manager; and Commissioners *Drs. Krohn; W. T. Casper,* Milwaukee; *Milton D. Davis,* Milton and *F. H. Wolf,* La Crosse. **Dr. A. J. McCarey,** a past president of the State Medical Society from Green Bay, was appointed for a three-year term on the Commission.

The Commission heard a report on a survey conducted recently of Wisconsin Plan companies to determine premium volume and enrollment. The enrollment now numbers 71,487 persons.

The Commission agenda covered a wide range of subject matter, including a sales report on special service contracts which showed an enrollment of 12,000 persons; a discussion of claims handling and experience; proposed revision of underwriting rules with respect to divorced subscribers; definitions of dependent children enrolled on WPS contracts; rules pertaining to conversion subscribers; merit rating and action of the Commission's Executive Committee in Prairie du Chien in late May.

Of particular interest was a report on impending termination of government supervision of tribal affairs for the Wisconsin Menominee Indians in northeastern Wisconsin, effective Feb. 1, 1957. Tribal officers, delegated to handle affairs for the 4,000 Menominees who will become regular citizens in another 18 months, have met with S.M.S. staff members to discuss methods of financing health care. Meetings will continue, with discussions expected to center around types of coverage, hospital facilities in the reservation area and ways of financing.

Commission Actuary **Carl Tiffany,** Chicago, computed rates for a revised Major Illness Expense Insurance program in line with an action of the Commission last March. He submitted three new approaches to provide coverage, as follows, all applicable to groups of 25 or more:

1. Replacement of basic Blue Shield benefits with a Major Illness policy which provides for a $50 initial deductible.

2. A "corridor" deductible of $100. Under this program, Major Illness benefits are provided after the expenditure of $100 out-of-pocket above the basic benefits.

3. A Major Illness program written in conjunction with the basic program with a deductible of $50 applicable only to charges other than for professional services.

Say AMA OK Needed To Integrate MD's and Osteopathic Doctors

MILWAUKEE—The president of the American Osteopathic Association believes that integration of medical physicians with osteopathic doctors "will come soon."

At the moment, Dr. Robert D. McCullough, of Tulsa, Okla., said recently, "it is the policy of the osteopathic profession to remain a separate school of medicine."

He said that the osteopathic concept of the importance of maintaining the proper functioning of bones and muscles was being recognized more and more by the medical profession.

PUSH FOR SAFETY BELTS STARTED BY SMS COMMISSION

Commission on State Departments Pledges All-Out Effort

MADISON — To make safety belts in cars effective, **they must meet rigid standards of manufacture and installation.**

To help make this possible, the Commission on State Departments has pledged to work with the State Motor Vehicle Department on the development of high standards.

The Commission action, on June 3, followed a recommendation of its Division on Safe Transportation. The Division action, in turn, followed a forceful plea by *Dr. Ervin L. Bernhart,* Milwaukee, immediate past-president of the State Medical Society, for all Wisconsin physicians to initiate a campaign for safety belts by installing them in their own cars.

TAKE THE LEAD!

Doctors in Wisconsin, Dr. Bernhart said, should take the lead in pushing installation of the belts in all vehicles. He said:

"By this example, I am sure much can be done to support the existing programs being carried out by community service groups promoting the use of the belts."

Commissioner Melvin O. Larson, of the Motor Vehicle Department, and his assistant, John Thompson, said the state agency was **"heartily in accord with the idea of high standards and legislation will have to pave the way."**

Thompson said State Traffic patrol officers have belts in their automobiles and their value had been proved on a number of occasions.

NEW DIVISION MEETS

Proposals calling for mandatory installation of the belts in cars of Wisconsin motorists were sidetracked in the 1955 legislature.

The Division on Safe Transportation newly-created by the Society's Council this spring, held its initial meeting June 2. Its chairman is Dr. Robert S. Gearhart of Madison.

Larson and Thompson also told the Division that persons with a record of epilepsy, who were given

Dr. Gearhart

permission to obtain drivers' licenses via legislation fostered by the Society, had a better safety record than the general driving public in Wisconsin last year.

They said two Wisconsin insurance firms were so convinced of the value of the current program they were now willing to write accident coverage for the epileptics found qualified to drive.

Dr. Carl N. Neupert, Madison, State Health Officer, reported that vital public health programs in Wisconsin are in danger from lack of funds and personnel.

"SERIOUS SITUATION"

"Right now," he declared, **"we are not going anywhere. We have real blocks to progress. Personnel is becoming discouraged. The situation is very serious.**

"The major cause of death in Wisconsin at present is chronic disease, and we are much concerned with such things as problems of the aged, early detection of cancer, heart ailments, tuberculosis and diabetes. Venereal disease is again on the increase.

"We are also much concerned with the need for public health nurses, the desirability of furthering developments in pre and post-natal care.

"County health departments are needed . . . and this probably will mean more taxes for all of us, but will be worth every dollar expended. These are just a few of the many fronts on which we are working, and it is frustrating to attempt to solve these problems without sufficient funds."

George A. Keith, of the State Department of Public Welfare, said the Department is being forced to consider competing with industry in training people for various services, because of personnel shortages.

DR. NEWCOMB CITED

In another action, the Commission adopted a resolution, introduced by Dr. H. A. Sincock, of Superior, eulogizing the faithful, humane efforts of *Dr. Kate P. Newcomb,* Woodruff, who died this spring, following hip surgery. Active in many causes, Dr. Newcomb was known nationally as the "angel on snowshoes."

She had been a member of the Divisions on Crippled Children and Maternal and Child Welfare.

Approved by the Commission were the following Division appointments:

Nervous and Mental Diseases—Dr. E. M. Burns of Madison; Public Assistance—Drs. C. M. Carney, Beloit and E. W. Schacht, of Racine; Geriatrics—Drs. C. A. Olson, Baldwin and B. F. Eckardt, Sheboygan;

(Continued on page 758)

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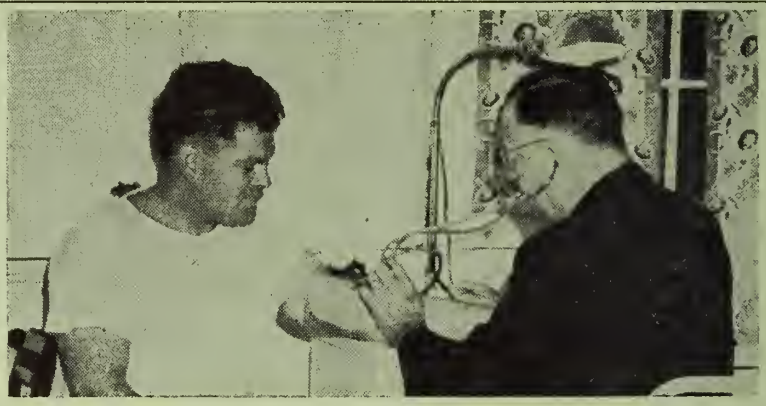

DR. GALE HUBER, of Minocqua, is shown at work at Camp American Legion near Lake Tomahawk. The patient was not identified. Dr. Huber spends one day a week at the camp, and is available for emergency calls at any time.

Lake Tomahawk, Wis. — Camp American Legion, a rest and rehabilitation haven for Wisconsin military veterans, and the only one of its kind in the country, is beginning its 31st year of service.

The camp, located on Little Tomahawk and Big Carr lakes, is a physical restoration project of the Wisconsin Department of the American Legion. The service is provided to all honorably discharged veterans of World Wars I and II and the Korean conflict, regardless of sex, creed or race, without cost. The veterans, who need not be Legion members, must come with a certification from their physicians that a period of rest and constructive rehabilitation will assist in recovery of health.

The camp physician is **Dr. Gale Huber** of Minocqua. He is assisted by a registered nurse, Mrs. Harold D. Bowen, wife of the camp superintendent. Dr. Huber spends one day a week at the camp, and is available for emergency calls at any time.

Officials reject certain mental, alcoholic and active tuberculosis cases, and veterans who have communicable diseases and long standing permanent total disability. These exceptions are necessary, the officials said, because the camp is not a hospital and cases requiring hospital care cannot be accepted. Only cases where rehabilitation can be accomplished are accepted.

In operation from June 1 to October 1 each year, the camp classifies patients in three categories, as follows:

GENERAL CARE — These patients are able to perform such tasks as making beds and cleaning the cabins. They are independent in self-care activities and able to walk with or without assistance of appliances, such as crutches and braces. Examples are ambulatory hemiplegics; amputees with prostheses of any type; psychiatric cases that are well oriented; cardiacs; respiratory patients and post-surgical cases.

MINIMAL CARE—This type is a partially ambulatory and wheel chair patient, but able to care for his personal activities, including propelling the chair. He must be able to sit for six to eight hours, assist in making a bed, dressing and the like. Examples are paraplegics; hemiplegics; amputees without leg prosthesis; orthopedic cases who are in cast, and neurological conditions that have no involvement of upper extremities.

MAXIMUM CARE — Here the patient would need aid in propelling a wheel chair, cleaning a cabin, making a bed and in preparing food so he may eat by himself. Examples are blind or severely disabled persons who have a desire to help themselves.

A new program of physical rehabilitation was installed on a pilot basis in 1955, with **Leslie M. Root**, chief correction therapist of the Veterans' Administration Hospital at Wood, Wis., in charge. Special equipment was obtained for work in physical restoration, including parallel bars, bar stairs, stationary bicycles, weight pulleys and the like.

The rehabilitation department also includes such enticing items as fishing equipment, woodworking tools, games and photography supplies.

There were 293 patients admitted into Camp American Legion last year. Records show 857 treatments in physical restoration. Ninety-six of the patients came from Milwaukee, 155 from out-of-state and 42 from Wood. The average length of stay was 16 days.

Some of the conditions or types of patients treated were arteriosclerosis, multiple sclerosis, Buerger's disease, muscular dystrophy, blind, post-polio, arthritis, arrested TB, cardio-vascular accident; chest, leg and shoulder gunshot wound, amputees and patients in for recuperation of injuries of various kinds.

Supt. Bowen has plans for increasing the rehabilitation program, by augmenting the physical and vocational divisions with the assistance of the State of Wisconsin Rehabilitation Department, as well as the Veterans' Employment Commission.

"We hope in time to have a complete home, or hospital, to job program for every patient that will come to Camp A.L. for this service. To accomplish this, we will have to increase our patient load, repair or enlarge some of our 22 cabins, put into use a beach for use of paraplegics, hemiplegics, amputee and certain orthopedic cases. We will have to enlarge and improve the treatment equipment as well as the recreational supplies now in use.

"We hope to add an M.D. specializing in rehabilitation, therapists, social and vocational experts and also vocational training."

The camp was established in 1925 by the Wisconsin Department of the American Legion, with a state grant and a lease with the

(Continued on page 757)

U.W. Professional Nursing Program Changed From Five to Four Year Course

MADISON — Is your daughter desirous of becoming a professional nurse with a degree?

If so, both of you undoubtedly will be happy to learn she probably will be able to earn her Bachelor of Science degree in nursing in four years, granted she enrolls at the University of Wisconsin next fall or later.

A new four-year program, recently approved by the U. W. Board of Regents and the Medical School faculty, will supplant a five-year curriculum and is designed to make the course more appealing to prospective candidates in the field of professional nursing.

LEARNING BY DOING—A student nurse is shown "learning to teach" a patient a treatment which the patient will need to give herself when she goes home from a hospital. The scene above was taken in a University of Wisconsin Nursing School class.

SEEK TO MODERNIZE

Worked out under the guidance and direction of Miss Margery Mac Lachlan, associate dean and director of the University of Wisconsin School of Nursing, the proposed revision seeks to modernize the course.

One nurse in eastern Wisconsin, learning of the proposed new schedule, had her doubts about its workability. She wrote:

"You'll find the girl fortunate who has attained all her credits and training in 5½ years . . . My sympathies to the undergraduate taking exams."

Miss Mac Lachlan, however, explained the course is being streamlined, with stress on pertinent subject matter. She said:

"It is hoped that we will be able to grant (after four academic years and three summer sessions) both the bachelor's degree and the certificate of graduate nurse and that our girls will have a background to become qualified for positions of leadership, both in administration and nursing education."

She said the first year of the program would consist of courses in general education. Nursing courses would begin during the first summer session. Theory and practice in the clinical areas would be presented concurrently.

SIMPLE TO COMPLEX

The total curriculum would be one of progression, Miss Mac Lachlan explained, with each course and each year building on the previous one. Each white capto-be would *"move from relatively simple problems in patient care to the more complex, and experiences would be given in planned nursing care with increasing responsibilities requiring the use of discriminating judgment."*

Instruction would include work in public health nursing, but the major will be in general nursing. Specialization will be on a post-baccalaureate level only, with four-year graduates eligible for admission to higher degree programs.

Miss Mac Lachlan added:

"With the growth and expansion of schools for practical nurses and hospital schools for nursing, the greatest need now is for preparation of instructors and administrators for these schools.

NEED EVIDENT

"The increasing demands for health services from schools, industry and public health agencies has produced a growing need for nurses with preparation in these areas. The University School of Nursing believes that with its limited funds, its primary role is to provide qualified nurses with basic preparation to function in these fields.

"Our program . . . is in keeping with modern trends in professional education."

Dr. Robert C. Parkin, coordinator of graduate education at the Wisconsin Medical School, hit on a subject closely allied to nursing education and practice when he said:

"I certainly believe that a serious look should be taken at the salary scale for nurses (as well as any curriculum revision), if we are going to continue to attract young women to this professional field."

Nursing has been described as a *"needed profession, a satisfying career with a secure future."* And certainly, any progress made in the field of nursing is manifested in the health and well-being of all humanity.

CAMP . . .

(Continued from page 756)

State Conservation Commission. The lease has been extended every 10 years by the legislature. Equipment belongs to the Legion organization, the land and buildings to the state. Until 1952, the camp was operated and improved with funds obtained by popular subscription. Since 1952, the 17-acre camp has been operated with funds obtained from Legion dues assessment.

FREEZE . . .

(Continued from page 751)

The medical consultants employed by the state must be able to reach the same diagnosis as the attending physician and, in addition, must be able to establish, from the findings of the attending physician, that the individual is prevented by his disability from engaging in substantial, gainful activity. Availability of work is not a consideration.

The reporting physician does not make the determination regarding disability, and hence does not carry responsibility other than to provide the essential information for review by the medical consultants in collaboration with disability determination supervisors.

CRITERIA DEVELOPED

Determinations are made on data supplied by all available sources. Criteria to aid in the decisions has been developed under the direction of a National Medical Advisory Committee.

The state agencies expressed appreciation for the *"splendid cooperation of the medical profession throughout Wisconsin in serving applicants in support of their disability claims."*

Physicians who have questions with respect to disability freeze determinations should address them to Pfeifer's office, or to district offices of the Rehabilitation Division in Eau Claire, Green Bay, Madison and Milwaukee. Sample copies of the revised form are also available.

Add Films to AMA Library

CHICAGO—Three new films were recently added to the AMA library for use by state and county medical societies.

They are:

"Alcohol and the Human Body" black and white, 10 minutes.

"Heart Disease—Its Major Causes"—black and white, 10 minutes.

"Tobacco and the Human Body" —black and white, 15 minutes.

Further information on any of these motion pictures may be obtained from the AMA Film Library in Chicago, or the State Medical Society, Madison, Wis.

Miss Holtshopple Named Pres.-Elect Of Assistants

Milwaukee — Audrey Holtshopple, of Janesville, was named president-elect of the Wisconsin State Medical Assistants Society at the organization's second annual meeting in Milwaukee, June 16–17.

Lois Pluckhan, of Madison, was installed as president, succeeding Alice Budny of Milwaukee.

Dorothy Loos, Milwaukee, was elected recording secretary; **Peggy Clark**, Madison, corresponding secretary and **Cherie Morgan**, of Bruce, treasurer.

The 1957 meeting will be held in Madison on June 8–9.

Leo E. Brown, director of the AMA Department of Public Relations, told the 150 assistants attending the Milwaukee meeting that the approach to their jobs should be a positive one. He said:

"Stress service and progress of medicine. The friendly touch which marked the old family doctor is needed today. The art of public relations is very closely associated with the art of human relations.

UNDERSTANDING VITAL

"Get the viewpoint, the understanding of your doctor's patients. The patient–physician relationship is all-important, with you assistants playing a vital role.

"You're a part of the team, and gaining more prestige all the time."

Dr. G. S. Kilkenny, of Milwaukee, president-elect of the Medical Society of Milwaukee County, praised the assistants for their efforts in organization, in helping their physician–employers, in public relations and service.

"You ladies are great assets to doctors," Dr. Kilkenny said. "Much depends on your efficiency and loyalty. I like your spirit. Your organization will be a success."

Officers of county associations affiliated with the state assistants society reported on activities on local levels.

Dr. Wayne J. Fencil, of Monroe, represented the State Medical Society's Council on Medical Service at the meeting.

ON THE S.M.S CALENDAR . . .

JULY

27–29—General Council and Council on Scientific Work, Land O'Lakes.

AUGUST

7—Claims Committee, SMS.

22–24—National Blue Cross–Blue Shield Public Relations Conference, Madison.

SEPTEMBER

4—Claims Committee, SMS.

7–9—Commission on Prepaid Plans and General Council, Manitowish.

11—Circuit Program, St. Francis Hospital, La Crosse.

12—Circuit Program, Sacred Heart Hospital, Eau Claire.

13—Circuit Program, St. Mary's Hospital, Superior.

OCTOBER

9—Circuit Program, Bellin Hospital, Green Bay.

10—Circuit Program, St. Joseph's–Lloyd Hospital, Menominee, Mich.

11—Circuit Program, St. Mary's Hospital, Wausau.

Doctor!

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation Inc.?

SAFETY BELTS . . .

(Continued from page 755)

Rehabilitation—Dr. R. L. Gilbert, La Crosse; School Health—Drs. Lloyd M. Simonson, Sheboygan and John G. Heisel, Superior; Crippled Children — Drs. D. W. McCormick, Fond du Lac; John Beyer, Madison and Everett C. Eickhoff, Land O'Lakes;

Visual and Hearing Defects—Drs. George Nadeau, Green Bay; C. G. Reznichek, Madison and Sidney B. Russell, Eau Claire; Maternal and Child Welfare — Drs. E. A. Birge, Milwaukee; T. V. Geppert, Madison and Kenneth Winters, Milwaukee; Tuberculosis and Chest Diseases—Drs. A. A. Pleyte, Milwaukee; F. B. Landis, Wood and Thor Gundersen of La Crosse.

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News Items and Personals

Doctor Gloss Appointed Health Officer

Dr. Albert Gloss, Fremont, was recently appointed health officer for that village by the village board. He succeeds Dr. W. F. Neuschafer in this post.

Doctor Gehin Named to Professional Group

Dr. F. E. Gehin, Stevens Point, has been notified that he has been accepted as a member of the American College of Physicians. Doctor Gehin is a 1943 graduate of the University of Wisconsin Medical School and completed his residency in internal medicine and cardiology at Wisconsin General Hospital in Madison. He located in Stevens Point in 1948.

New Clinic Opened at Plymouth

Drs. H. A. Weisse and *L. J. Steffan* recently moved into their new clinic at Plymouth. Drs. Steffan and Weisse mapped the plans for the Plymouth Medical Clinic several years ago and began construction on the building last November. Clinic facilities are such that two or three more doctors can easily be added to the staff.

Doctor Troup Locates in Green Bay

Dr. R. H. Troup recently started practice in Green Bay after receiving his master's degree in urological surgery from the University of Minnesota.

Doctor Troup received his medical education at Northwestern University, served his internship at Cook County Hospital in Chicago, and was a fellow in urology at the Mayo Foundation in Rochester, Minnesota.

Doctor Caswell Honored

Dr. H. O. Caswell, Ft. Atkinson, was honored May 28 by the Ft. Atkinson Lions Club. A "This Is Your Life" program was presented in recognition of Doctor Caswell's long service to the community.

Doctor Heersma Elected Fellow in Pediatrics

Dr. J. R. Heersma, Marshfield, was one of 179 doctors elected to fellowship in the American Academy of Pediatrics, it was announced recently.

A native of Oak Lawn, Illinois, Doctor Heersma joined the Marshfield Clinic in 1953.

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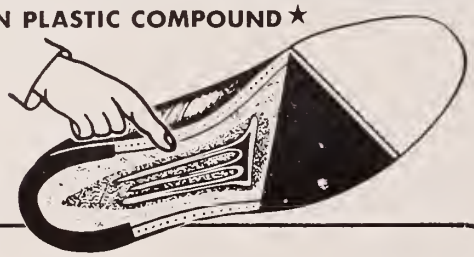

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THIRD AND TWELFTH DISTRICTS NEWS

Doctor Curreri Speaks on Cancer

Dr. A. R. Curreri, director of the Cancer Research Hospital of the University of Wisconsin, addressed 25 women's organizations at the Community Center in Madison on May 17.

The attending organizations have participated in the cancer dressings program of Madison. Doctor Curreri described cancer research to the group.

Doctor Curtis Heads Heart Association

Dr. J. K. Curtis, chief of medicine and tuberculosis at the Veterans Administration Hospital, Madison, recently took office as president of the Wisconsin Heart Association.

The appointment was made at the association's annual meeting on June 2 held at the Veterans Administration Hospital in Madison.

Doctor Skroch Returns from Service

Dr. E. E. Skroch, Madison, has returned to resume the practice of surgery in association with the East Madison Clinic after 18 months of active duty.

A 1943 graduate of the University of Wisconsin Medical School and a veteran of World War II, Doctor Skroch entered service in 1954 for duty with the Navy on the west coast.

Doctor Coon Accepts Milwaukee Post

Dr. H. M. Coon, superintendent of University Hospitals in Madison, recently accepted the post of Milwaukee County Hospital Administrator. He will assume the new position about September 1.

Doctor Coon will succeed *Dr. H. W. Sargeant*, who will retire February 1, 1957, when he reaches the mandatory retirement age of 70.

Doctor Weston Honored

Dr. Frank Weston received the "distinguished service citation" of the Alumni Association of the University of Wisconsin on June 16.

He was honored for serving as a teacher, acting on the athletic board of the University of Wisconsin, and participating in veterans affairs.

Doctor Jackson Presents Lectures

Dr. Arnold S. Jackson, Madison, recently returned from a lecture tour in which he addressed the Mississippi State Medical Meeting, a medical meeting at Jackson, Mississippi, and a joint meeting of the North and South Dakota state medical societies at Aberdeen, South Dakota.

BETTER

results are obtained with STERANE[1]—3 to 5 times more active than hydrocortisone or cortisone.

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capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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J. W. Rupel, 2320 North Lake Drive, Milwaukee.

J. L. Coryell, VA Hospital, Wood.

H. B. Leppink, Milwaukee County Hospital, Milwaukee.

Christine J. Ivanov, 3308 North Downer Avenue, Milwaukee.

J. S. Horning, 9025 West Hampton, Milwaukee.

S. R. Gambino, St. Luke's Hospital, Milwaukee.

Anne L. High, 1048 East Lexington Boulevard, Milwaukee.

D. E. Hampel, 3461 North 16th Street, Milwaukee.

R. L. Annis, Milwaukee County Hospital, Milwaukee.

W. C. Southcott, 324 East Wisconsin Avenue, Milwaukee.

R. J. Schweitzer, 99 Lawrence Avenue, Tuckahoe, New York.

R. C. Meade, VA Hospital, Wood.

S. C. B. Goldberg, 7480 North Lombardy Road, Milwaukee.

J. W. Herbert, 1146 Grant Street, Beloit.

B. W. Beattie, Antigo.

Muriel Joan D. Hege, 424 North Patterson Street, Madison.

G. S. Hogle, 1300 University Avenue, Madison.

D. E. Koepke, 2750 North 84th Street, Milwaukee.

G. M. Kroncke, 1300 University Avenue, Madison.

Changes of Address

C. H. Burnett, Eagle River, to VA Hospital, Wood.

H. E. Froede, Milwaukee, to 3511 Legation Street, N.W., Washington, D. C.

A. T. Holbrook, Dunedin, Florida, to 2928 East Kenwood Road, Milwaukee.

J. P. Koehler, St. Petersburg, Florida, to Route 1, West Bend.

G. A. Dedinsky, Smock, Pennsylvania, to 2568 East 17th Street, Salt Lake City, Utah.

T. E. Kilkenny, New Orleans, Louisiana, to 119 McDowell Street, Delavan.

R. G. Evenson, Marshfield, to Footville.

E. K. Steinkopff, Janesville, to District TB Hospital, Lima, Ohio.

W. G. Bear, St. Petersburg, Florida, to Monroe.

J. K. Theisen,** Camp Stewart, Georgia, to 119 Ledgeview Avenue, Fond du Lac.

T. H. McDonell, Marshfield, to 203 Hoover Avenue, Waukesha.

H. M. Buckner, Mount Horeb, to Dodgeville.

C. W. Horswill, River Falls, to 4224 Doncaster Drive, Madison.

R. H. Troup, Eagle River, to 130 East Walnut Street, Green Bay.

J. W. Brooks, Madison, to Medical College of Virginia, Richmond, Virginia.

L. G. Patterson, Waupaca, to Route 2, Box 450, Largo, Florida.

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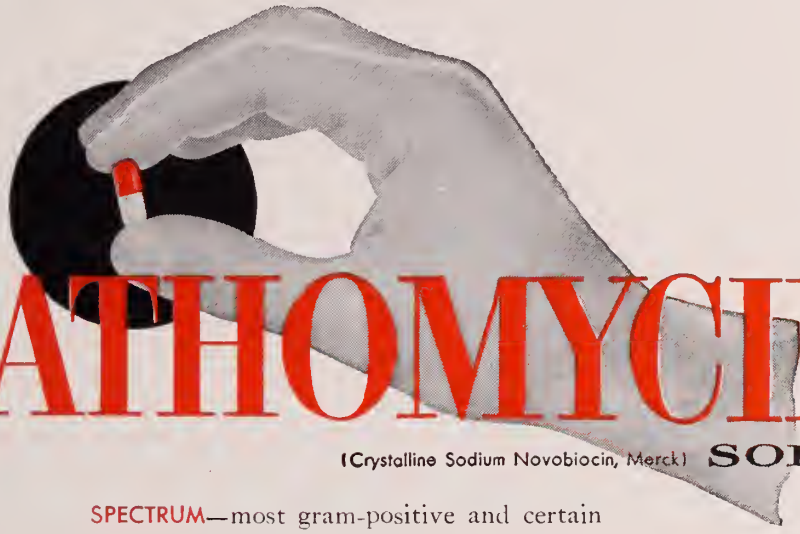

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WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

The Case for Service Benefits*

The basic principle of service benefits is that an individual will be insured against a particular type of medical or surgical care which he may require and that by being so insured will receive the necessary professional services from the physician of his choice without payment to the participating physician. The physician is paid by the insuring plan. It is obvious from this definition of the service benefit principle that the physician who agrees to render service benefits is obligating himself to accept a fixed fee for a particular type of service. The fee which he agrees to accept must be considered an "average" one for there is no means of determining in advance the degree of complexity which will confront the physician at the time the service is rendered. It is also manifestly impossible to determine, on an equitable basis, the relative severity of identical operative situations with different patients and different surgeons.

Service benefits, therefore, represent the physician's guarantee to the patient that if he should require a particular service it will be rendered him without additional charge by the physician regardless of the severity of the condition at the time of operation.

Service benefits seem to me to be the natural development of the ideals and traditions of the medical profession when the profession becomes a part of plans to insure individuals against the cost of their medical care. In fact, I do not see what other course of development was possible in keeping with medical traditions.

It has always been understood by both patient and physician that doctors of medicine assume the obligation of providing necessary medical care with no reference to, or prior determination of, the ability of the patient to pay. While this idealistic principle has been somewhat qualified by the materialism of our times and the physician's own problem of providing adequately for himself and his family during his relatively short years of high professional earnings, it still remains the guide by which medicine is practiced by the vast majority of physicians.

On this basis it does not seem proper to me for a physician to enter into the support and underwriting of a medical care plan with the idea that the plan payments would defray, only in part, the cost of his services to the low income patient. By so doing he is in effect guaranteeing payment to himself and also leaving himself free to make additional charge to the patient. I cannot recall any previous situation in medicine wherein physicians were party to arrangements which benefited themselves more than their patients. Thus, to me the Blue Shield Indemnity Plan fails to measure up to the standards of the medical profession.

Service benefits are all that Blue Shield has to sell!

* William H. Horton, M. D., Executive Director, Connecticut Medical Service, Inc., New Haven, Connecticut.

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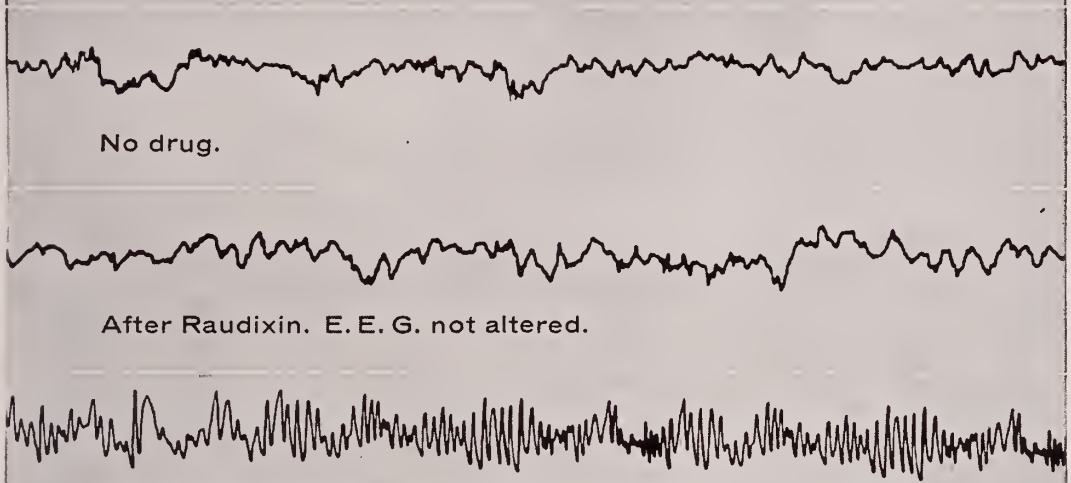
Comparison of the effect of Raudixin (tranquilizer) and a barbiturate (sedative) on the cortical electroencephalogram



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Because barbiturates and other sedatives depress the cerebral cortex, the sedation achieved is accompanied by a reduction in mental alertness.

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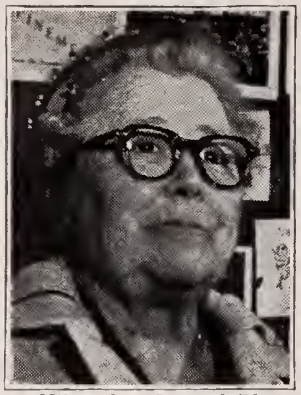
OBITUARIES

Dr. Kate Pelham Newcomb, 70 years of age, died at a Wausau hospital May 30 after undergoing an operation to correct a fractured hip.



—*Milwaukee Journal Photo*

KATE P. NEWCOMB

Doctor Newcomb was born in 1885 in Wellington, Kansas, and later moved to Boston. In 1917 she was graduated from the University of Buffalo Medical School, and she interned at Woman's Hospital, Detroit. Specializing in obstetrics, she first practiced in New York and later in Detroit.

When her husband became ill in 1922, they moved to Vilas County in Wisconsin. Doctor Newcomb did not practice again until 1931, when a nearby physician asked her to assist him in handling a dire medical emergency. Later that same year the physician prevailed upon her to obtain her Wisconsin license, and since that time she had continued to practice in the northern Wisconsin area, an area covering a radius of approximately 70 miles.

She was chief of staff and founder of the Lakeland Memorial Hospital at Woodruff and served on the staffs of Sacred Heart Hospital in Tomahawk, and St. Mary's Hospital in Rhinelander.

She was a member of the Oneida-Vilas County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the American Academy of General Practice, the Wisconsin Academy of General Practice, and the New York Academy of Science.

"Doctor Kate" received national recognition in 1954 when she appeared on the television program, "This Is Your Life." After her appearance, donations came from all parts of the country to be added to the money collected during the "million pennies campaign" which townspeople in the northern Wisconsin area had conducted to help build Lakeland Memorial Hospital.

Earlier this year a biography of Doctor Newcomb entitled "Angel on Snowshoes" was published.

Surviving are her husband, William; one son, Thomas; an adopted daughter, Eldorah; and four grandchildren.

RESOLUTION

WHEREAS, Kate Pelham Newcomb, M. D., of Woodruff, Wisconsin, through her faithful participation in the activities of the Division on Maternal and Child Welfare and the Division on Crippled Children for a period of many years, contributed greatly to the programs of the State Medical Society of Wisconsin for better public health and the finest type of medical care, and

WHEREAS, Doctor Newcomb displayed throughout her life of medical practice the finest traditions of scientific medicine and a deep understanding of that treasured attribute known as the art of medicine, and

WHEREAS, The sincerity, faithfulness, and loving kindness that won for her the friendship and esteem of thousands whom she knew and served was enhanced by a zeal and perseverance that ultimately produced a modern medical facility for the northern Wisconsin area in which she lived; now, therefore, be it

Resolved, That the members of the Commission on State Departments of the State Medical Society of Wisconsin place on record their high appreciation of their late associate and fellow member, and be it further

Resolved, That this resolution be communicated with heartfelt sympathy to her family and the community she served, and in addition be placed in *The Wisconsin Medical Journal* as a memorial to a fine family physician and a truly devoted public servant.

Adopted by the Commission on State Departments of the State Medical Society of Wisconsin, at Madison, Wisconsin, June 3, 1956.

T. W. TORMEY, JR., M. D., *Chairman*
C. H. CROWNHART, *Secretary*

Dr. A. Gilbert Rowley, of Middleton, died at the home of his daughter on May 24 at the age of 81 years.

Doctor Rowley, who was of the third generation of Rowley doctors to practice in the Middleton area, received his medical degree from Rush Medical School in Chicago in 1899. He began his practice in Middleton in 1902.

Surviving are his wife, Ottilie; two daughters, Mrs. Charles Lubcke, and Jessica; and one grandchild, all of Middleton.

Dr. Herschel C. Danforth, Janesville, died at his home on May 20. Born on July 2, 1898, at Friendsville, Illinois, he was 57 years of age at the time of his death.

Doctor Danforth received his medical degree from Wayne University Medical School in 1928 and interned at St Joseph Mercy and Grace hospitals in Detroit. Prior to coming to Janesville in 1933, he had practiced in Detroit, Marion, and Flint, Michigan. He had been with General Motors as a plant physician in Janesville before entering private practice in that city.

Special medical groups in which Doctor Danforth held membership included the American Association of Industrial Physicians and the Association of American Railway Surgeons. He belonged to his local Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His wife, Christine; two sons, John B., Fort Atkinson attorney, and Robert C., University of Wisconsin medical student; two grandsons; a stepmother; one brother; and three sisters survive.

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1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Esophageal Surgery, One Week, September 24
Breast & Thyroid Surgery, One Week, October 22
Gallbladder Surgery, 3 Days, October 29
Fractures & Traumatic Surgery, Two Weeks, October 15

GYNECOLOGY & OBSTETRICS—Obstetrics & Gynecology, Three Weeks, October 22
Office & Operative Gynecology, Two Weeks, September 17
Vaginal Approach to Pelvic Surgery, One Week, September 10

MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, October 8; One-Week Advanced Course, September 17
Internal Medicine, Two Weeks, September 24
Gastroscopy & Gastroenterology, Two Weeks, September 10
Gastroenterology, Two Weeks, October 22
Dermatology, Two Weeks, October 15
Cardiology (Pediatrics), Two Weeks, November 5

RADIOLOGY—Diagnostic X-Ray, Two Weeks, September 17
Clinical Uses of Radioisotopes, Two Weeks, October 8

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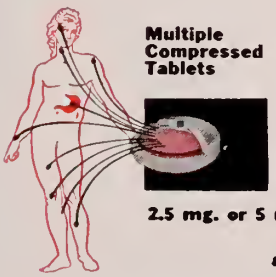

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References: 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* **158**:459, June 11, 1955.

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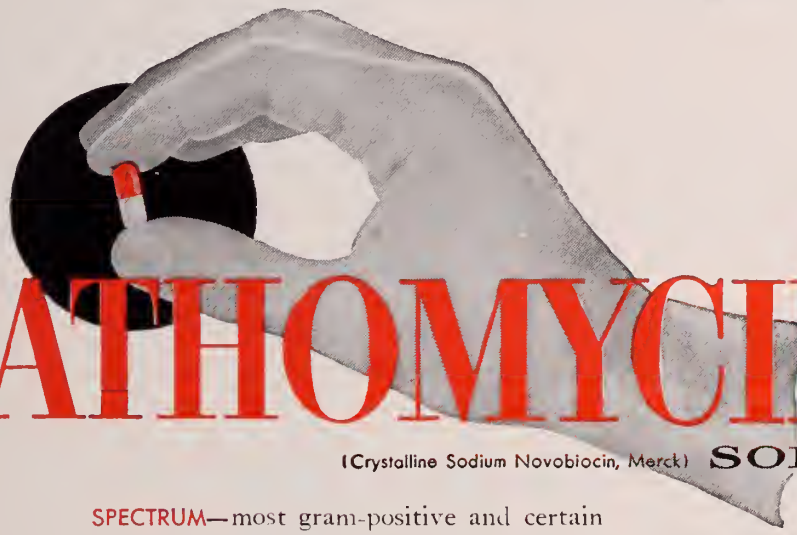

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2. Hollander, J. L., *et al. J.A.M.A.* **158**:476, June 11, 1955.

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Physiology of Heart and Circulation and Its Clinical Application in Physical Medicine. A symposium presented at the twenty-seventh annual conference of The American Physical Therapy Association, Cleveland, Ohio, June 26–30, 1950. Livingstone, New York, Livingstone Press, 1951. Price $1.00.

This symposium attempts to promote understanding of basic physiological principles as they relate to physical medicine. The purpose of the symposium is accomplished in a highly successful manner. This is to be expected when a review of the contributors to the symposium reveals such outstanding physiologists as Drs. Alexander, Bouman, Hertzman, Hines, Keller, Opdyke, Randall, and Wise.

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The information presented is based upon research done in many laboratories. The importance of this symposium is the presentation of physiological facts and their correlation with clinical medicine.—C. W. C.

Correlative Cardiology: An Integration of Cardiac Function and the Management of Cardiac Disease. By Carl F. Shaffer, M. D., F.A.C.P., Associate Professor of Clinical Medicine, Baylor University College of Medicine; and Don W. Chapman, M. D., F.A.C.P., Associate Professor of Medicine, Baylor University College of Medicine. Philadelphia and London, W. B. Saunders Company, 1952.

This text of 525 pages is concisely presented in outline form. The method of presentation is designed to correlate the phases of anatomy, physiology, pathology, and abnormal or pathologic physiology that pertain to the diagnosis and treatment of cardiac disease. The illustrations are good. References are included following each chapter. The information presented is factual and without discussion.

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INDEX TO ADVERTISERS

	Page
American Meat Institute	702
Ayerst Laboratories	777
Baker Laboratories	698
Barr X-Ray Company	782
Bayer Company	690
Benson Optical Company	769
Breon, George A., & Company	706
Brown and Williamson Tobacco Corp.	774
Burroughs Wellcome & Co., Inc.	771
Canada Dry	764
Ciba Pharmaceutical Products	761
Continental Baking Company	705
Cook County Graduate School of Medicine	772
Davies, Rose & Co., Ltd.	759
Doerflinger Artificial Limb Co.	760
Endocrine Laboratories	779
Foot-so-Port Shoe Company	760
Geigy Pharmaceuticals	699
Gyne-Cytology Laboratory	760
Hotel Schroeder	759
House of Bidwell	769
Hurley X-Ray Company	759
Keeley Institute	750
Kennedy Mansfield	776
Lakeside Laboratories	689, 694, 772
Lederle Laboratories	689, 730, 731
Lilly, Eli and Company	708
Mallard, Incorporated	777
Mallatt Pharmacy	776
Mather Pharmacy	776
Medical Protective Company	782
Milwaukee Sanitarium Foundation, Inc.	784
New York Polyclinic	750
Orthopedic Appliance Company	782
Parke, Davis and Company	686, 687
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	763, 781
Physicians Casualty Association	762
Professional Business Service	755
Rennebohm's	776
Rogers Memorial Sanitarium	784
S. and L. Signal Company, Inc.	779
Sacred Heart Sanitarium	776
St. Croixdale Sanitarium	689
Schering Corporation	697, 700, 701 opposite 702, 707
Schmid, Julius, Inc.	703
Searle, G. D. and Company	747
Smith, Kline & French Laboratories	696, 749
Sharp and Dohme	691, 692, 693, 765, 773, 775, 778
Shorewood Hospital Sanitarium	761
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp	767
Time Insurance Company	753
Tutag, S. J., and Company	688
Wallace Laboratories	704
Winthrop Laboratories	695
Wisconsin Neurological Foundation	772
Wyeth	770

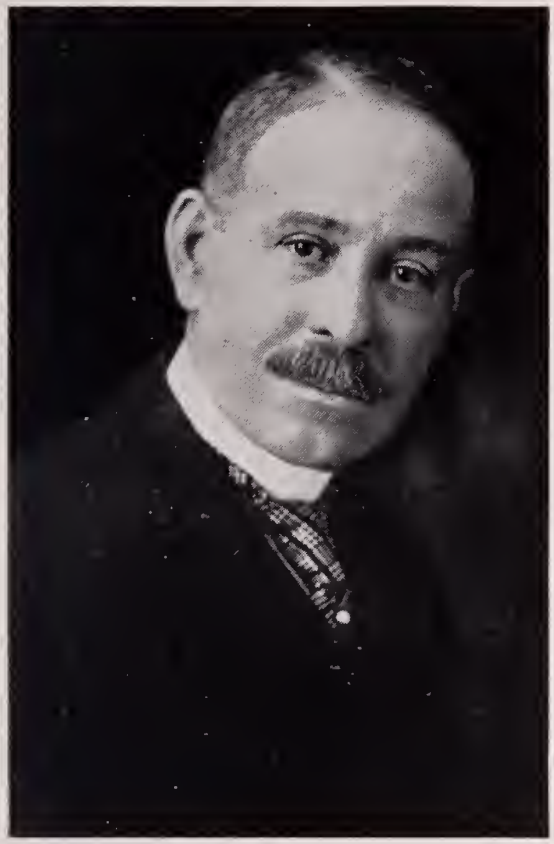

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Hypaque Sodium, A New Urographic Contrast Medium, by Tom E. Nesbitt, M. D., N. W. Bourne, M. D., and D. P. Babbitt, M. D.	815
The Treatment of Hemophilus Influenzae, Type B, Meningitis; A Report of 6 Cases Treated With Chloramphenicol, by E. H. Pawsat, M. D.	820
Meckel's Diverticulum, by C. F. Althaus, M. D.	823
The Management of Cryptorchidism, by James F. McIntosh, M. D.	825
Clinicopathologic Conference	828
Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists	833
Comments on Treatment	836
A Look Into the Future at Lake Tomahawk State Camp	837

MISCELLANY

	Page
Circuit Teaching Programs—1956–1957	841
Transactions of the 1956 Regular Session, House of Delegates, State Medical Society of Wisconsin	842
Attendance at House of Delegates, May 1, 2, and 3, 1956	904
Society Proceedings	915
News Items and Personals	918
Third and Twelfth Districts News	921
Society Records	922
Obituaries	924
Facts About Wisconsin Physicians Service	927
Physicians' Exchange	928
Index to Advertisers	930

EDITORIALS

	Page
The President's Page	838
Professional Integrity and Responsibility	839
Applied Integrity	840

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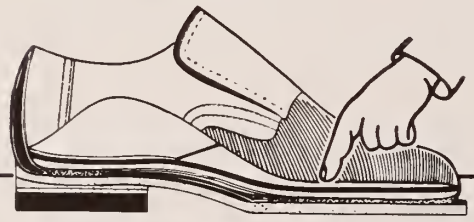

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SPECTRUM—'CATHOMYCIN' [1,2,3,5,6] has also been shown to be active against other organisms including—*D. pneumoniae*, *N. intracellularis*, *S. pyogenes*, *S. viridans* and *H. pertussis*, but clinical evidence must be further evaluated before 'CATHOMYCIN' can be recommended for these pathogens.

ACTION—'CATHOMYCIN' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.[7]

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(Crystalline Sodium Novobiocin, Merck)

ABSORPTION—'CATHOMYCIN' is readily absorbed, [5,6,9] and oral dosage produces significant blood and tissue levels which persist for at least 12 hours.[7]

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DOSAGE: Four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED: 'CATHOMYCIN' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

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REFERENCES:

1. Wallick, H., Harris, D.A., Reagan, M.A., Ruger, M., and Woodruff, H.B., *Antibiotics Annual*, 1955-1956, New York, Medical Encyclopedia, Inc., 1956, pg. 909.
2. Frost, B.M., Valiant, M.E., McClelland, L., Solotorovsky, M., and Cuckler, A.C., *Antibiotics Annual*, 1955-1956, pg. 918.
3. Verwey, W.F., Miller, A.K., and West, M.K., *Antibiotics Annual*, 1955-1956, pg. 924.
4. Kempe, C.H., *Calif. Med.*, **84** 242, (April) 1956.
5. Simon, H.J., McCune, R.M., Dineen, P.A.P., Rogers, D.E., *Antib. Med.*, 2:205, (April) 1956.
6. Lubash, G., Van Der Meulen, J., Berntsen, C., Jr., Tompsett, R., *Antib. Med.*, 2:233, (April) 1956.
7. Lin, F.-K., Coriell, L.L., *Antib. Med.*, 2:268, (April) 1956.
8. Limson, B.M., Romansky, N.J., *Antib. Med.*, 2 277, (April) 1956.
9. Morton, R.F., Prigot, A., Maynard, A. de L., *Antib. Med.*, 2:282, (April) 1956.
10. Nichols, R.L., Finland, M., *Antib. Med.*, 2:241, (April) 1956.
11. Mullins, J.F., Wilson, C.J., *Antib. Med.*, 2:201, (April) 1956.
12. David, N.A., Burgner, P.R., *Antib. Med.*, 2:219, (April) 1956.
13. Martin, W.J., Heilman, F.R., Nichols, D.R., Wellman, W.E., and Geraci, J.E., *Antib. Med.*, 2:258, (April) 1956.
14. Milberg, M.B., Schwartz, R.D., Silverstein, J.N., *Antib. Med.*, 2:286, (April) 1956.

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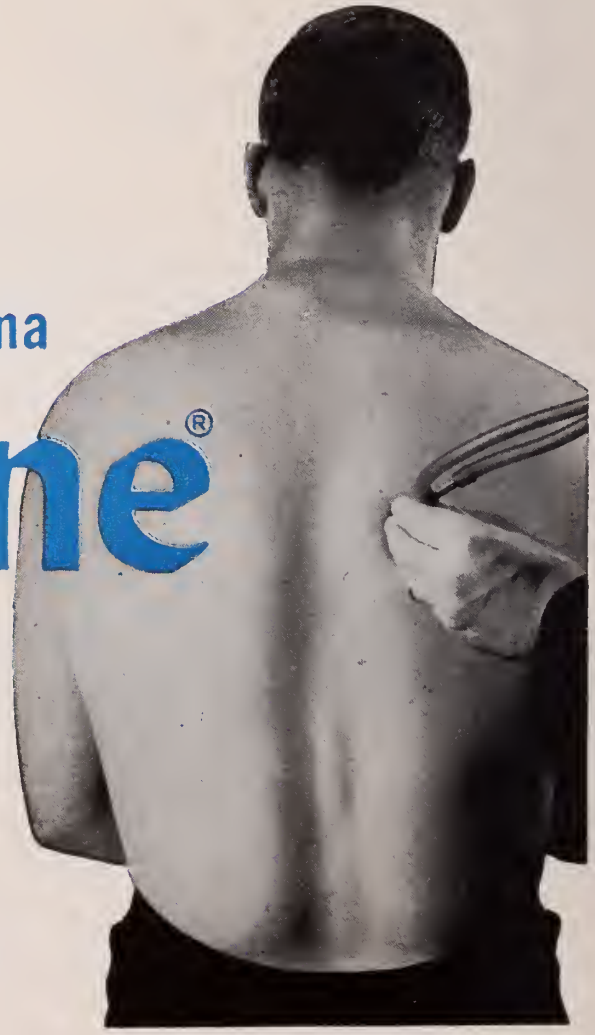

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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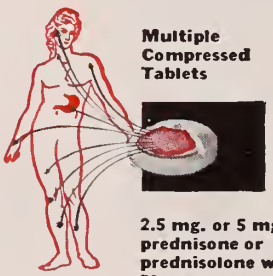

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References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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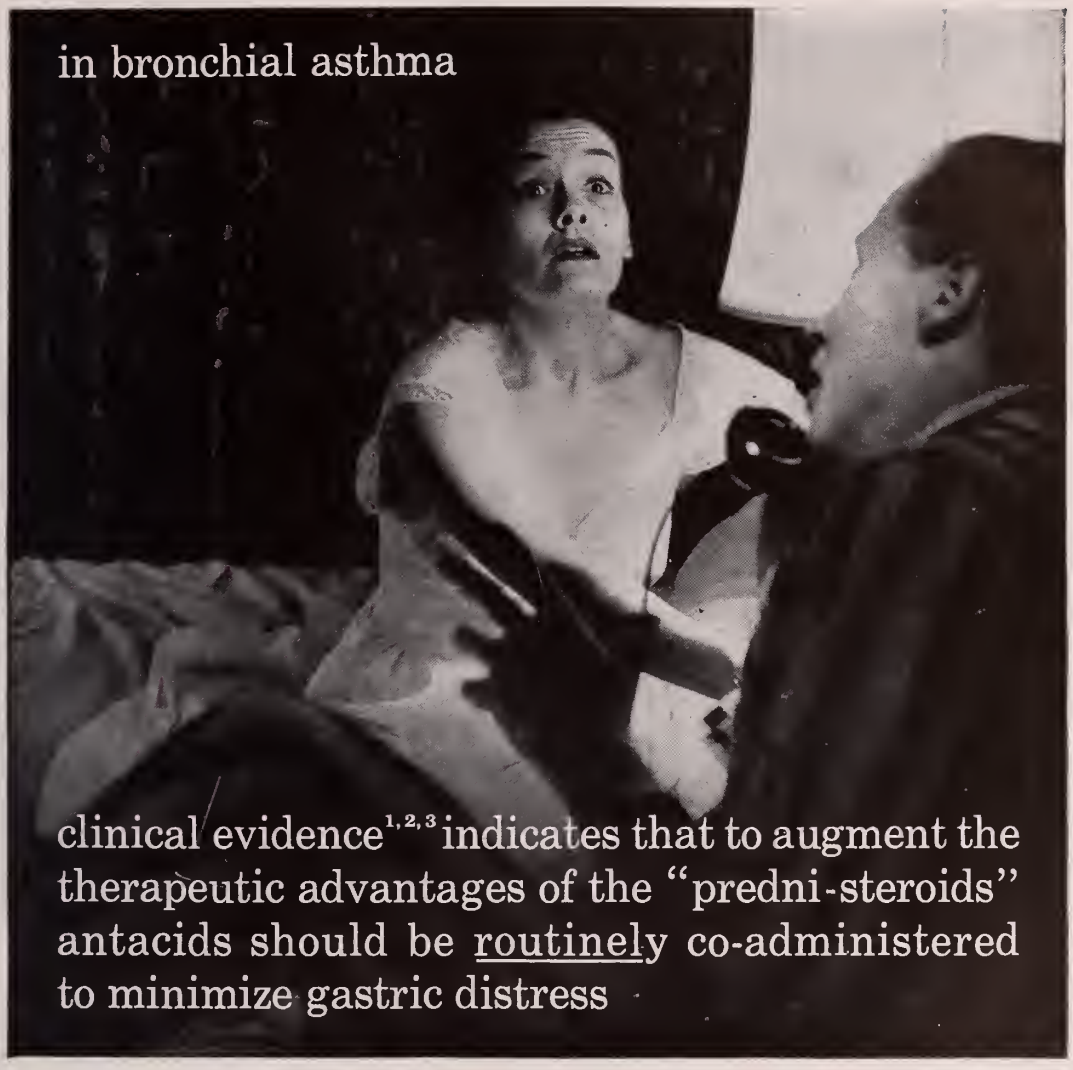

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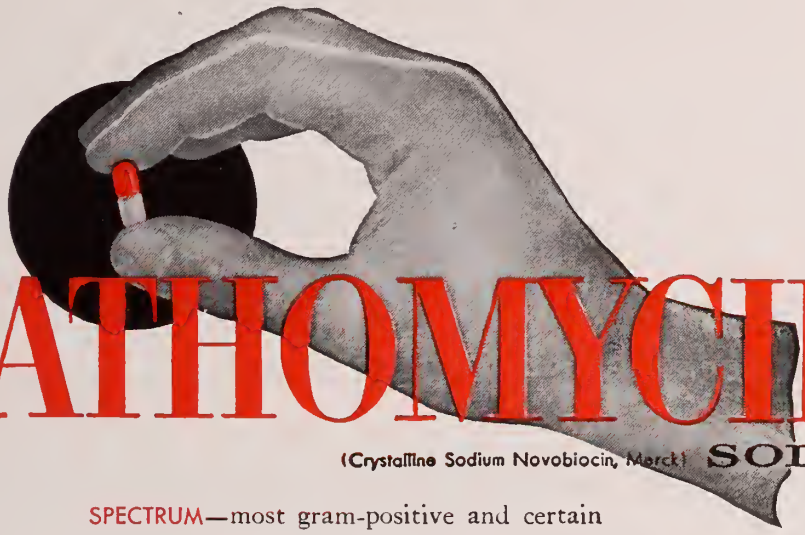

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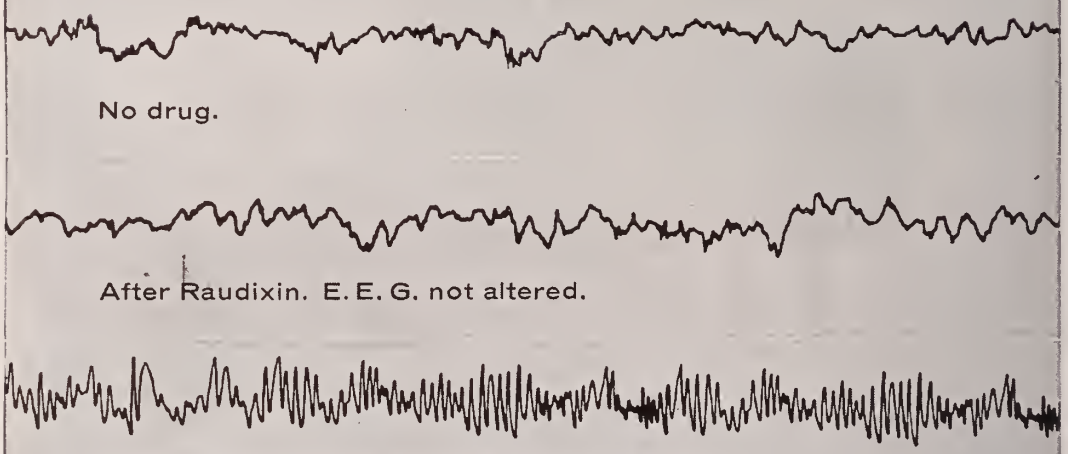

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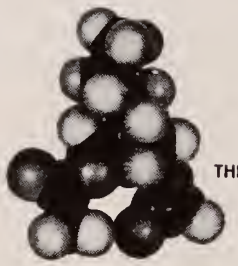

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*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

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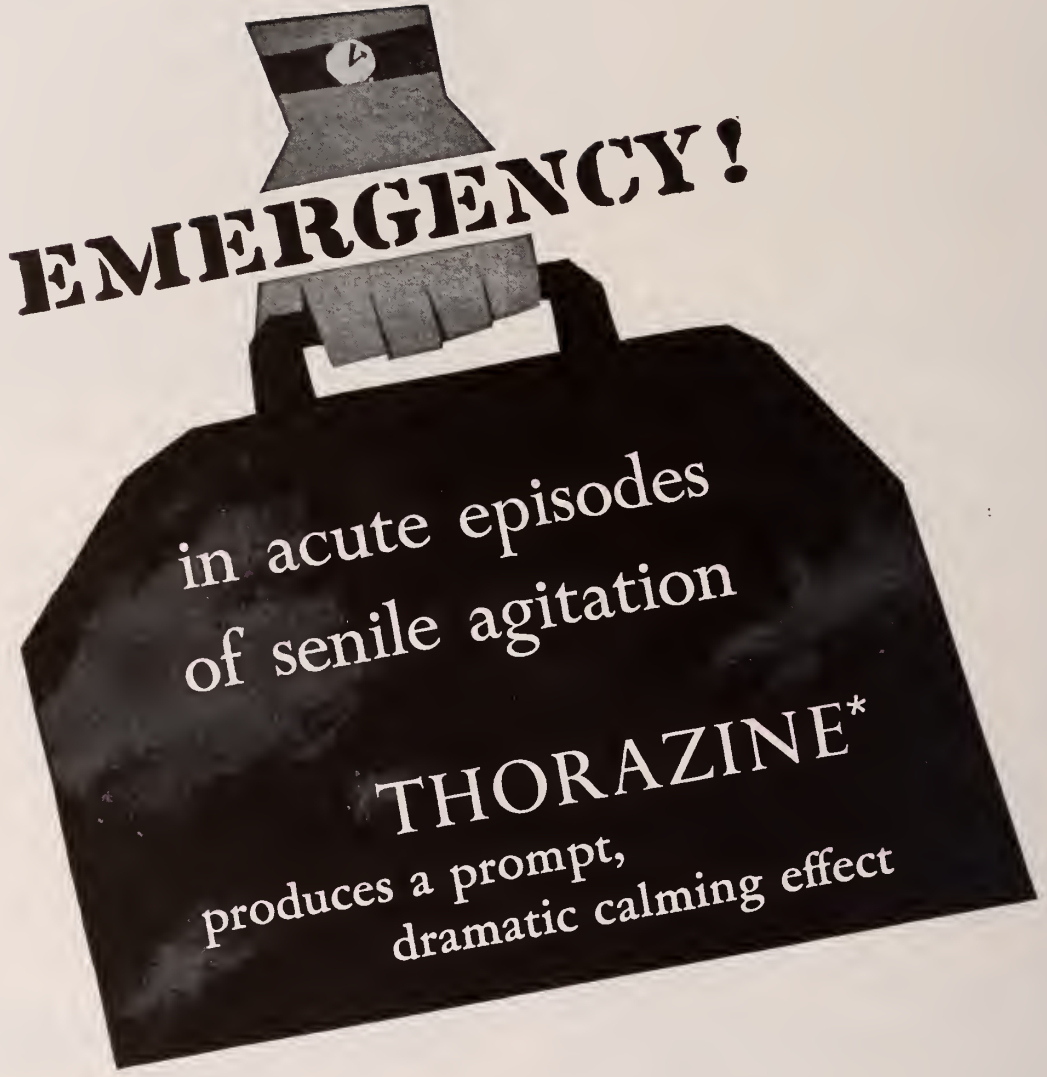

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1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of Rauwolfia Serpentina Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, J. Am. Chem. Soc. 76:2843 (1954).

2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toekes, M.I., and Ungari, J.: Pharmacological Studies with Rescinnamine, a New Alkaloid Isolated from Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 86:120 (May) 1954.

3. Gourzis, J.T.; Sonnenschein, P.R., and Barden, R.: Alterations in Cardiovascular Responses of the Dog Following Rauwiloid, an Alkaloidal Extract of Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 85:463 (Mar.) 1954.

4. Hershberger, R.; Hughes, W., and Dennis, E.: Clinical Results in the Treatment of Hypertension with Rescinnamine, Clin. Res. Proc. 3:71 (Feb.) 1955.

5. Smirk, F.H., and McQueen, E.G.: Comparison of Rescinnamine and Reserpine as Hypotensive Agents, Lancet 2:115 (July 16) 1955.

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Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

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THE WISCONSIN MEDICAL JOURNAL

Volume 55 AUGUST 1956 Number 8

Hypaque Sodium, A New Urographic Contrast Medium*

By TOM E. NESBITT, M. D., N. W. BOURNE, M. D., and D. P. BABBITT, M. D.
Milwaukee

A SIGNIFICANT advance in the field of excretory pyelographic media was made with the introduction of the triiodobenzoate compounds. One of these, Urokon, has become established as an accepted medium for intravenous and retrograde urography.[1,2] Numerous clinical studies have demonstrated that these triple iodide compounds provide a more satisfactory degree of radiographic contrast by reason of a higher molecular iodine content than that of such available diiodo compounds as Diodrast and Neo–Iopax. The diagnostic advantage of Urokon has been partially offset by a relatively high incidence of annoying and sometimes severe side reactions. In recent months a related triiodobenzoate product, known commercially as Hypaque Sodium, has appeared; it offers the advantages of older compounds and at the same time is virtually without objectionable reactions.

Widespread use of the intravenous pyelogram for defining the anatomical and functional patterns of the kidney has encouraged the development of products which approach an ideal standard. A utopian substance would be one which, when injected intravenously, would be totally nontoxic and furnish universally satisfactory x-rays of the renal collecting system. It is likely that such will never be achieved, yet any advance in this direction is noteworthy. Extensive studies on experimental animals have demonstrated that the toxicity of Hypaque is considerably lower than that of Diodrast and somewhat less than that of Urokon.[3] The intravenous minimum lethal dose is in the range of 10,000 to 12,000 mg/kg. of body weight in animals, and such a dosage exceeds many times any likely clinical dose. The quality of pyelograms obtained with Hypaque in previously reported preliminary studies[4,5] and confirmed in this report is equivalent to, if not superior to, that reported with any other contrast medium in any concentration currently available commercially. At the outset, then, it would appear that Hypaque represents a substantial advance toward an ideal intravenous contrast medium.

Method of Excretion

Hypaque is a diacetylamine of sodium triiodobenzoate. It is a highly water-soluble compound having a molecular weight of 636 and containing 59.8% iodine. It is supplied by the manufacturer as a 50% solution in a 30 ml. ampule containing 8.97 gm. of iodine for intravenous use.[3] For all practical purposes the excretion of Hypaque is exclusively the function of the kidney. It may be recovered from the urine in an unchanged state almost immediately after intravenous administration. Slightly more than 80% is eliminated within 4 hours and over 90% within 24 hours.[3] The actual mechanism of Hypaque excretion remains a matter of conjecture, although it may be assumed to be similar to that of Urokon excretion as the two compounds differ chemically only in that an additional acetylamine group in the 5 position on the benzene ring is present in the Hypaque molecule. There is evidence to indicate that Urokon and presumably Hypaque are excreted primarily as a result of glomerular filtration rather than by tubular secretion, which is somewhat contrary to older and existing beliefs regarding the renal extraction of intravenous contrast media.[6]

*Presented at the annual meeting of the North Central Section of the American Urological Association, Chicago, September 30, 1955.

This is best explained by two postulates. First, the introduction of 30 ml. of Hypaque containing almost 9 gm. of iodine into the vascular bed produces a plasma iodine concentration of 200 to 300 mg. %, far in excess of the maximum tubular excretory capacity, thereby permitting the molecule to appear in the glomerular filtrate in high concentration. Second, the triiodobenzoate compounds are thought to possess a lesser affinity for protein.[1] A diminished protein-binding capacity would allow a greater percentage of free circulating molecules with resultant increased molecular diffusibility and production of a higher excretory load. This would permit a more rapid excretion of contrast material and may provide an explanation for the earlier roentgenographic appearance of this contrast medium following injection than of such diiodo products as Diodrast or Neo–Iopax.

An understanding of the method of excretion of intravenously injected contrast material is of more than passing interest and is perhaps worthy of additional comment at this time. It seems obvious that the advantage of the triiodo compounds, as far as pyelographic quality is concerned, is primarily a matter of the ability of these compounds to provide more iodine per unit of fluid space. With this as a common factor, further variations in quality will then depend upon the preparation of the patient, that is, his state of hydration, and on the status of renal function. Thus, the importance of proper dehydration becomes clear. As the contrast medium is excreted primarily by glomerular filtration, it is mandatory that the tubular system form a concentrated urine in order to attain maximum iodine concentration in the collecting system. By contrast, if the renal tubules form a dilute urine, there will be a corresponding dilution of iodine in the pelvis and calyceal system.

Since these particular iodide preparations exhibit such an obvious glomerular excretory predilection, it might be expected that the pyelogram would also serve as a differential test of renal function as well as an index of fluid balance. Practically, however, it is difficult to separate disease entities into pure glomerular or tubular problems. Almost invariably there is coexistence to some degree. Thus, the ability to excrete Hypaque is not indicative of the degree of function of any particular portion of the nephron; but failure to excrete it bespeaks of severe underlying glomerular dysfunction. Therefore, any patient who has been properly dehydrated prior to intravenous urography and fails to have satisfactory x-ray demonstration of the renal collecting system must be suspected to have intrinsic glomerular disease and should have function studies in the form of creatinine clearance or urea clearance tests.

Clinical Study

In this study Hypaque was used for a total of 537 consecutive intravenous pyelograms performed in the radiology department of Milwaukee Hospital and in the authors' private office. The patients were unselected as to any known existing disease. Preparation consisted principally of dehydration and giving cleansing laxatives for hospitalized patients. No preliminary testing procedures were employed prior to intravenous injection. It is the authors' conviction that none of the testing procedures have proved satisfactory, and numerous reports have been published pointing to the lack of correlation between such ocular and intradermal tests and subsequent clinical response following intravenous pyelography.[2,4,7] The rate of injection was a uniform one which varied from three to five minutes. All injections were performed by physicians, who observed the patients and recorded reactions. The optimum exposure times were found to be five minutes and ten minutes following injection. A preliminary film was taken routinely and also an upright film after the ten-minute film. Immediate processing was carried out; and should one or both kidneys have failed to visualize, delayed exposures were made at varying intervals, up to twenty-four hours later in some instances. Each patient was questioned carefully about any known allergies and specifically about iodine sensitivity. Vital signs of blood pressure, pulse, and respiration of 50 patients were recorded before and after injection.

Results

There were 17 patients who had a history of known allergies or drug sensitivities; among them were 4 who had shown definite iodine sensitivity at the time of previous examination. Only 2 of these people exhibited any side effect, and in both this consisted of the mildest form of a transient flush with some nausea lasting less than one minute.

Fig. 1—"Fair" quality pyelogram

Fig. 2—"Good" quality pyelogram.

No significant variations in blood pressure, pulse, or respiration were observed in the cases in which these were recorded, and this phase of the study was then discontinued.

Each set of pyelograms was graded as to quality according to the nature of excretion of the contrast medium. Admittedly, any such grading plan is subject to the vagaries of individual interpretation and as a consequence is presented with some reservations. "Poor" films were obtained in only 2% of the patients and comprised those x-rays in which the excretion of Hypaque was totally unsatisfactory. "Fair" films were obtained in 8% of the patients and denoted instances where there was visible Hypaque excretion but of insufficient quality to allow a definite diagnosis (fig. 1). Pyelograms were rated as "good" in 39% of the cases; these were films sufficiently dense for diagnostic purposes with a satisfactory delineation of all shadows, of the calyces, the renal pelvis, and the upper ureter (fig. 2). A grading of "excellent" was given to 51% of the pyelograms and designated a radiographic quality comparable to retrograde pyelograms, with detail definition and contrast density (fig. 3,

Fig. 3—"Excellent" quality pyelogram.

NOTE: The original photographs indicated a better radiographic quality than that shown in the reproductions in this article—some of the details have been lost in the processes of engraving and printing.

TABLE 1—*Pyelogram Quality—50% Hypaque*

Grading	No. of Cases	Percentage
Excellent	272	51%
Good	210	39%
Fair	42	8%
Poor	13	2%
	537	100%

table 1). About 90% of the films were considered adequate for the expression of a definite opinion as to the diagnosis.

An evaluation of secondary systemic responses to the intravenous injection of radiographic contrast material also imposes the limitations of individual interpretation. To establish criteria those reactions which were objectionable to the patient were considered as significant, in the sense that the individual would undergo an identical examination a second time with some reservations and reluctance as a result of his reaction to the initial injection. Using this method of evaluation, such objectionable reactions were encountered in 34 patients, only 6.3% of the group (table 2). None of these patients required supportive measures such as oxygen, antihistamine drugs, barbiturates, or Adrenalin. All reactions were so mild as to have totally disappeared within five minutes, and none interfered with completion of the x-ray study. This singularly important feature of Hypaque becomes the basis for its superiority to other contrast media. Each case of vein cramp or arm pain observed was localized to the site of venapuncture and in each instance was associated with extravasation of Hypaque in varying amounts at the site of injection.

TABLE 2—*Objectionable Reactions—50% Hypaque 537 Cases—34 Reactions (6.3%)*

Sweating and salivation	1
Choking alone	1
Choking and flushing	2
Vein cramp with nausea or flushing	3
Vein cramp (or localized arm pain) alone	6
Nausea and flushing alone	9
Nausea and/or vomiting with flushing, sweating, choking, or wheezing	12
	34

A group of insignificant side effects were also elicited. These were in no way annoying and would not have been recorded except for the fact that each patient was specifically questioned as to the presence or absence of these mild symptoms by name after having been given the opportunity of voluntarily describing any reaction he might have experienced. There were 81 patients who gave a negative answer when asked if they noticed anything unusual following the injection but who would admit to a fleeting, mild sensation of warmth or flushing, a vague transient metallic taste, a mild momentary suggestion of nausea, or some combination of these when asked specifically about such sensations. These were all so inconsequential as to be considered insignificant in a critical evaluation of objectionable side effects or reactions.

Retrograde Use

More recently, Hypaque has been used routinely for retrograde pyelography. The manufacturer has prepared a 20% solution supplied in sterile 20 ml. ampules. This concentration has now been utilized in over 100 consecutive cases for routine retrograde study without any untoward reactions such as flank pain during or following injection or a febrile response. The solution appears to be of optimum viscosity and provides an ideal contrast density. It has furnished excellent delineation of both negative and positive shadows without the obscuration of finite details often encountered with other retrograde media. Figure 4 exemplifies the quality of a retrograde pyelogram obtained in a patient who had also had an excretory pyelogram, which is shown for comparison. It is our initial impression that Hypaque in this form may well prove as superior as that used intravenously.

Summary and Conclusions

A new urographic contrast medium has been subjected to the trials of clinical usage. It was used in 537 patients for excretory pyelography and in over 100 patients for retrograde urography.

In the intravenous form, Hypaque was supplied as a 50% solution in 30 ml. quantities. Approximately 90% of the films obtained were satisfactory for diagnosis, being termed either excellent or good quality. The group of patients whose x-rays were fair or poor in quality comprised 10% of the total and almost without exception were found to have some form of renal or vascular disease accounting for the diminished excretion. With 50% Hypaque one can expect to obtain universally satisfactory excretory pyelograms in the absence of reduced renal function when proper preparation is employed and accepted x-ray techniques exercised.

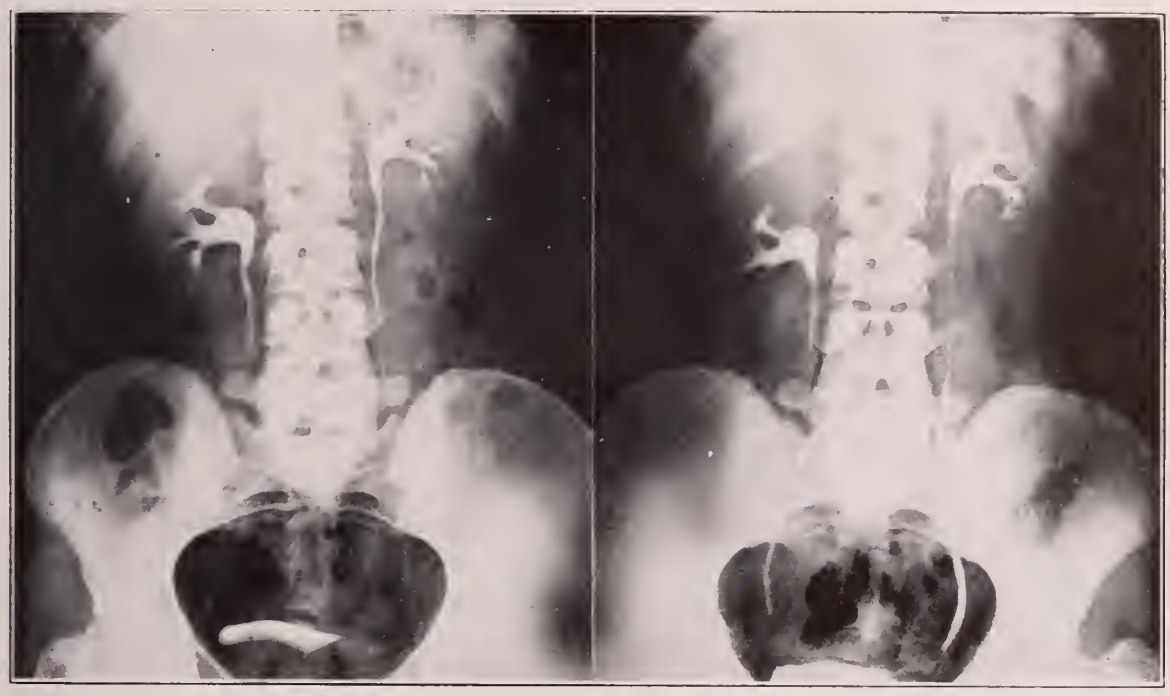

Fig. 4—A. Intravenous pyelogram with 50% Hypaque.

B. Retrograde pyelogram with 20% Hypaque on same patient, illustrating quality of films and favorable density obtained with retrograde medium.

Objectionable reactions were encountered in only 6.3% of the patients, none of whom required supportive measures. This relatively innocuous nature of Hypaque has been a singularly impressive feature.

The likely method of Hypaque excretion has been presented to emphasize the role of glomerular filtration and the importance of adequate dehydration.

Limited experience with a 20% solution of Hypaque for retrograde urography has been gratifying in that resulting x-rays have been of optimum density and reactions have not been encountered.

Hypaque Sodium would appear to be a superior urographic contrast medium with minimum toxicity and maximum efficiency, closely approaching an ideal standard.

(T.E.N.) 208 East Wisconsin Avenue.

REFERENCES

1. Nesbit, R. M., and Nesbitt, T. E.: Experiences with high concentration Urokon for pyelography, Univ. Michigan M. Bull. 18:225–231 (Aug.) 1952.
2. Porporis, A. A., Zink, O. C., Wilson, H. M., Barry, C. N., Royce, R., and Rose, D. K.: Routine clinical experiences using Urokon Sodium 70% in intravenous urography, Radiology 60:675–685 (May) 1953.
3. McAuliff, J. P., and McChesney, E. W.: Data in files of Sterling–Winthrop Research Institute.
4. Lowman, R. M., Shapiro, H., Lin, A., Davis, L., Korn, F. E., and Newman, H. R.: Preliminary clinical evaluation of Hypaque in excretory urography, Surg., Gynec. & Obst. 101:1–8 (July) 1955.
5. Moore, T. D., and Mayer, R. F.: Hypaque: improved medium for excretory urography. Preliminary report of 210 cases, South. M. J. 48:135–141 (Feb.) 1955.
6. Porporis, A. A., Elliott, G. V., Fischer, G. L., and Mueller, C. B.: Mechanism of Urokon excretion, Am. J. Roentgenol. 72:995–1003 (Dec.) 1954.
7. Mullen, W. H., Jr., and Hughes, C. R.: Intravenous urographic contrast media, Am. J. Roentgenol. 68:903–914 (Dec.) 1952.

OF INTEREST TO PHYSICIANS HAVING X-RAY TECHNICIANS ON THEIR STAFFS

The Wisconsin Society of X-ray Technicians will hold its annual convention at the Stoddard Hotel, La Crosse, September 14–15, and will have a two-hour refresher course given by Clark T. Warren, R. T., past president of the American Society of X-ray Technicians, on the morning of each day. The course is being introduced to bring the technicians up to date on the latest techniques used in everyday x-ray procedure.

The Treatment of Hemophilus Influenzae, Type B, Meningitis

A Report of 6 Cases Treated With Chloramphenicol*

By E. H. PAWSAT, M. D.**
Fond du Lac

Reduced Mortality and Morbidity

IN THE past 20 years mortality due to *Hemophilus influenzae*, type b, meningitis in infants and children has been reduced from practically 100%, in the absence of specific treatment, to less than 5%, with presently available therapeutic agents. The latter figure, it must be understood, represents a mortality rate achieved in the treatment of relatively large series of patients at medical centers under optimal conditions for diagnosis and treatment. The over-all mortality rate for influenzal meningitis in this country probably does not begin to approach the 5% figure. Equally as important as the dramatic reduction in mortality by prompt and adequate treatment are the improved morbidity rates and the prevention of neurologic sequelae in survivors of the infection.

Considerations in Diagnosis

It is not generally appreciated that the incidence of influenzal meningitis appears to be on the increase and, in many localities, is higher than that of any of the other purulent meningitides. This point should be taken into consideration in any therapeutic approach to purulent meningitis prior to the isolation of the causative organism.

Since the infant under 1 year of age seems especially susceptible, this age group accounts for the majority of cases of this infection. Unfortunately, this is also the age group in which meningeal signs are not always obvious at an early stage of the infection.

Another factor which tends to delay diagnosis and treatment is the indiscriminate use of antibiotics and sulfonamides in the absence of a definite diagnosis. This type of therapy may mask an early meningeal infection.

For these reasons it is especially imperative that the spinal fluid of the infant be examined when any sign suggests meningeal involvement or when, in the absence of other findings, suspicion is directed to the central nervous system.

Casual diagnosis and treatment of an upper respiratory tract infection, otitis media, gastroenteritis, or bronchopneumonia may easily deceive the hurried clinician into overlooking a more serious associated influenzal meningitis.

Evolution of Present-Day Therapies

Before discussing the treatment of influenzal meningitis with chloramphenicol, it might be well to review briefly the evolution of the present-day therapies for this disease. Initial, though very limited, success came with the use of various types of serum[1] and sulfanilamide. Later, chemotherapeutic agents included sulfapyridine and sulfadiazine either with or without specific antiserum. Alexander's, type b, anti-influenzal rabbit serum was at this time quite generally accepted as the best antiserum. At this stage of therapeutic control of influenzal meningitis, some 15 years ago, the mortality of the disease was still over 50%. Streptomycin,[2] either alone or in conjunction with other of the above therapies, was next reported as further reducing the mortality rate of influenzal meningitis; its addition as an effective agent in the treatment of this form of meningitis helped to reduce the mortality to some 20%.

Intrathecal use of some of these drugs was tried, but this route seemed to offer no advantages over less tedious and, certainly, less dangerous routes of administration. More recently, especially within the past five years, Aureomycin, Terramycin, and chloramphenicol have been used either singly or in combination with previously described drugs for the treatment of influenzal meningitis.[3-5]

*Presented before the Milwaukee Pediatric Society, Milwaukee, June 1, 1955.

**From the Department of Pediatrics, St. Agnes Hospital, Fond du Lac, Wisconsin.

H. Influenzae Meningitis—Treatment of 6 Patients with Chloramphenicol

Case	Age	Duration of Meningitis Symptoms	Route of Therapy	Dosage	Duration of Therapy	Supportive Therapy
P. W. ‡	6 mos.	48 hrs.	Oral (gavage initially)	100 mg./kg.	9 days	Adrenal cortex Parenteral fluids
N. L.	4½ yrs.	16 hrs.	I.V. drip Oral Oral	75 mg./kg. 75 mg./kg. 50 mg./kg.	2 days 2 days 7 days	2 transfusions
J. S.*	9 mos.	24 hrs.	Subcutaneous Subcutaneous Oral	50 mg./kg. 66 mg./kg. 50 mg./kg.	2 days 2 days 8 days	2 transfusions
C. W.†	13 mos.	24–48 hrs.	Subcutaneous Oral Oral	45 mg./kg. 68 mg./kg. 45 mg./kg.	2 days 5 days 7 days	2 transfusions
D. M.	7 mos.	20 hrs.	I. V. Subcutaneous Oral	200 mg./stat. 75 mg./kg. 50 mg./kg.	1 day 9 days	
M. A.	7 mos.	72 hrs.	Oral	62 mg./kg.	11 days	1 transfusion

‡Penicillin, Aureomycin, and sodium sulfadiazine also given until diagnosis was established.
*Penicillin and sodium sulfadiazine also given until diagnosis was established.
†Penicillin and sulfadiazine also given for 5 days in presence of otitis media and bronchopneumonia.

This increasing number of therapeutic agents, all with some degree of specificity towards the *H. influenzae,* type b, organism, makes one hesitate before suggesting a treatment of choice.

Chloramphenicol Therapy

A review of the recent literature on this subject seems to point to certain advantages of chloramphenicol over other drugs in the treatment of influenzal meningitis. Chloramphenicol may be given effectively intravenously, intramuscularly, or subcutaneously when the parenteral route is necessary.[6] The intramuscular and subcutaneous routes of administration are especially helpful to the physician not skilled in intravenous therapy in the infant-aged child. Moreover, the drug rarely causes gastrointestinal disturbances such as vomiting and diarrhea when given orally. Adjuvant specific therapy does not seem to be necessary. There is little tendency for a relapse of the infection as was rather common with some of the former therapies. This drug usually produces a negative spinal fluid culture in 24 hours and good clinical response within 72 hours. Early reports seem to have overemphasized the toxic effects of the drug. Nevertheless, the potential danger of certain blood dyscrasias still warrants adequate blood studies when therapy with chloramphenicol is prolonged or repeated.

In 1952, Scott and Walcher[6] reported good results in 6 patients with influenzal meningitis treated with chloramphenicol by the intravenous and oral routes in daily doses of 50 mg./kg. of body weight.

In 1953, Smith and Herring[7] reported the treatment of a large series of patients with bacterial meningitis which included 32 patients with *H. influenzae* as the etiological agent. In their experience, they felt that chloramphenicol was the treatment of choice in this disease.

Report of Cases

The chart shows an additional 6 patients with influenzal meningitis treated with chloramphenicol at St. Agnes Hospital, Fond du Lac, Wisconsin, over the past two years. The daily dosage of the drug, except in Case 1, approximated 50 mg./kg. of body weight and was given initially by intravenous and subcutaneous routes if the patient was comatose or unable to retain medications. It is believed that these patients were seen and treated in a relatively early stage of the disease. Several of the patients had received some form of antibiotic therapy prior to admission. The diagnosis was made by identifying the causative organism by spinal fluid smear in 4 patients, spinal fluid culture in 1 patient, and blood culture in 1 patient. Direct typing of the organism was not done.

Combined therapies were used only until the diagnosis was established in Cases 1 and 3. In Case 4, combined therapy was used for a period of five days in the presence of otitis media and bronchopneumonia.

The palmitate form of the drug was not used because of the questionable complete absorption of the chloramphenicol incorporated in this vehicle. Blood studies, including platelet counts, done periodically throughout the courses of treatment revealed no evi-

dence of toxicity of chloramphenicol. In 2 patients granulocytes dropped to 12% and 16% respectively for a few days but rose again to normal levels in spite of continued therapy. It is felt that these changes, as well as the concurrent anemia which developed in most patients, were probably the result of the infection rather than evidence of toxicity of the therapeutic agent.

Response to therapy was good in all 6 patients, and no apparent complications developed. Evidences of subdural collections of fluid, subarachnoid abscess, and localized paralysis of the extremities were watched for especially.

All patients have been followed for from one month to two years without evidence of neurologic sequelae, except in Case 1. This child, now 2½ years of age, has an exotropia considered to be neurologic in origin. The condition was first noted by the parents when the child was 11 months of age. Surgical correction is anticipated. Oddly, this patient, on admission, had a relatively high spinal fluid sugar (51 mg.%) and showed good clinical response to the higher chloramphenicol dosage. Hyperpyrexia, to 106.8 (r), may have been a factor in the occurrence of this sequela.

Conclusions

In conclusion, it is my impression, on the basis of study of available literature and experience with an admittedly small series of cases, that *H. influenzae*, type b, meningitis, if seen early, can be treated effectively with the single drug chloramphenicol. A daily dosage of 50 mg./kg. of body weight of chloramphenicol probably is adequate. Therapy should be continued for one week following evidence of clinical improvement. Results with such treatment seem to be equally as favorable as, if not superior to, those with other forms of therapy.

44 South Marr Street.

REFERENCES

1. Wilkes–Weiss, D., and Huntington, R. W., Jr.: Treatment of influenzal meningitis with immune serum, J. Pediat. 9:462–466 (Oct.) 1936.
2. Alexander, Hattie E.: Streptomycin in pediatrics, J. Pediat. 29:192–198 (Aug.) 1946.
3. Drake, M. E., Bradley, J. E., Imburg, J., McCrumb, F. R., Jr., and Woodward, T. E.: Aureomycin in treatment of influenzal meningitis, J.A.M.A. 142:-463–465 (Feb. 18) 1950.
4. Prather, G. W., and Smith, Margaret H. D.: Chloramphenicol in treatment of Hemophilus influenzae meningitis, J.A.M.A. 143:1405–1406 (Aug. 19) 1950.
5. Schoenbach, E. B., Spencer, H. C., and Monnier, J.: Treatment of H. influenzae meningitis with Aureomycin and chloramphenicol; experience in 30 consecutive cases, Am. J. Med. 12:263–276 (March) 1952.
6. Scott, J. R., and Walcher, D. N.: Intravenous chloramphenicol in treatment of meningitis due to Hemophilus influenzae (type B), J. Pediat. 41:-442–444 (Oct.) 1952.
7. Smith, Margaret H. D., and Herring, G. W.: Treatment of acute bacterial meningitis in infants and children, Postgrad. Med. 14:540–545 (Dec.) 1953.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

APPLICATION FOR CERTIFICATION

Applications for certification, American Board of Obstetrics and Gynecology, for the 1957 Part I examinations are now being accepted. Candidates are urged to make such applications at the earliest possible date. The deadline date for receipt of applications is Oct. 1, 1956.

All candidates for admission to the examinations are required to submit with their application a plain typewritten list of all patients admitted to the hospitals where they practice for the year preceding their application or the year prior to their request for reopening of their application.

Application for re-examination, as well as requests for resubmission of case abstracts, must be made to the secretary prior to Oct. 1, 1956.

Current bulletins outlining present requirements may be obtained by writing to:

ROBERT L. FAULKNER, M. D., *Secretary*
American Board of Obstetrics and Gynecology
2105 Adelbert Road
Cleveland 6, Ohio.

Meckel's Diverticulum*

By C. F. ALTHAUS, M. D.
Sunnyvale, Calif.

LADD, in Christopher's *Textbook of Surgery*, estimates that persistence of the vitello-intestinal duct, or part of it, known as Meckel's diverticulum, occurs in 2 to 4% of infants. What percentage develop pathological change is not known, but there are several changes that may occur. The duct may:

1. Remain attached to the umbilicus with a patent duct, producing an intestinal fistula or "weeping navel."
2. Remain attached to the umbilicus by a fibrous nonpatent band.
3. Become attached to some other point in the peritoneal cavity. Any of these attachments can cause intestinal obstruction.
4. Become acutely inflamed, resulting in a diverticulitis.
5. Contain aberrant gastric mucosa and ulcerate, with resultant hemorrhage or perforation.
6. Invert into the ileum and be the start of an intussusception.

The general practitioner who does surgery is aware of these conditions that can confront him in the acute abdomen, but although his postgraduate training and current reading keep him alerted to the possibilities that exist, it perhaps is more significant when a case is reported from a practice similar to his own since it emphasizes that the unusual can and does occur with no respect for percentages or total case-load figures.

Case Report

The case being presented is that of an acutely ill 14-year-old girl who was first seen at 10 p.m., Feb. 22, 1956, with the following history.

On February 19, she had experienced a persistent pain around the umbilicus with malaise and anorexia. By February 21 her symptoms had subsided somewhat; but on February 22 she had severe pain throughout the lower abdomen, vomited once, and became febrile.

Six hours after the onset of the severe lower abdominal pain she looked pale, drawn, and apprehensive. Her temperature was 100.4 F., her pulse 96, and respirations 22. The abdomen was quiet, with marked tenderness and muscle guarding in both lower quadrants and rebound tenderness. There was no vaginal discharge, and on digital examination of vagina and rectum there appeared to be more tenderness in the right iliac fossa than in the left. The urine was negative and the white blood cell count 20,250, with 90% neutrophils and 10% lymphocytes.

A diagnosis of appendicitis with peritonitis was made and the patient prepared for surgery with 100 mg. of Seconal, 10 mg. of morphine, and 0.3 mg. of atropine.

A right rectus muscle splitting incision was employed, and on opening the peritoneum a large amount of purulent fluid was encountered. Suction was employed to clear the abdomen; and the cecum was mobilized and brought into the wound, revealing an appendix with increased vascularity but obviously not the primary pathology. The uterus and adnexa were entirely normal. The stomach, duodenum, and gallbladder were also normal. An ovarian-sized mass felt in the lower abdomen was brought into the operative wound. This proved to be a large Meckel's diverticulum located approximately twenty-four inches from the ileocecal valve. It was 2 inches long and 1 inch wide at the base and indurated at the junction of the middle third and proximal third, where there was a perforation ⅛ inch in diameter with the pale friable border typical of a perforated gastric ulcer. A heavy fibrous cord extending from the tip of the diverticulum to the umbilicus was ligated, a clamp laid transversely across the base of the diverticulum, and the diverticulum excised. Angle sutures were placed and mattress sutures of No. 000 chromic gut laid over the clamp. As

*Presented at meeting of Wisconsin chapter, Academy of General Practice, Boscobel, Wisconsin, June 11, 1956.

the clamp was withdrawn, traction on the angle sutures kept the resulting defect closed while the mattress sutures were tied. A layer of Halstead mattress sutures of No. 60 cotton was then placed in the serosa. The angulation of the bowel at the site of the diverticulum that had resulted from the constant traction exerted by the obliterated segment of the vitello-intestinal duct was corrected by the closure with no reduction of the lumen.

An incidental appendectomy was done and the wound closed in layers after a Penrose drain had been brought out through a stab wound. Two small rubber drains were placed after the closure of the peritoneum to provide wound drainage. The postoperative course was uneventful, with the drains removed and the patient out of bed on the second day.

Summary

A 14-year-old girl presenting the clinical picture of a ruptured appendix was found on exploration to have a perforated ulcer in a large Meckel's diverticulum.

374 West Washington Street.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	12:15 p.m.
WHSA	Brule	Friday	10:30 a.m
WHKW	Chilton	Friday	10:30 a.m
WCHF	Chippewa Falls	Saturday	9:45 a.m.
WHWC	Colfax	Friday	10:30 a.m
WHAD	Delafield	Friday	10:30 a.m
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Friday	10:30 a.m
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	5:00 p.m
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	1:00 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Friday	10:30 a.m
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:45 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Friday	10:30 a.m
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	11:00 a.m.
WBKV	West Bend	Saturday	11:15 a.m.
WHLA	West Salem	Friday	10:30 a.m

The Management of Cryptorchidism

By JAMES F. McINTOSH, M. D.
Madison

UNDESCENDED testis, or cryptorchidism, is a rather common congenital anomaly that is still not completely understood. The treatment of this condition is varied, and recently some investigative work has been performed that is quite enlightening as to the probable fate of repaired testes. The purpose of this paper is to point up some of the aspects of management.

The testes are extraperitoneal organs until just prior to or just after birth, at which time they descend into the scrotum via the inguinal canal. An extension of the peritoneal sac known as the processus vaginalis invests the testis and descends with the testis and spermatic cord through the internal inguinal ring and into the inguinal canal. These structures later emerge through the subcutaneous inguinal ring and descend into the scrotum. The testicular covering then loses its connection with the abdominal cavity as the proximal end of the processus vaginalis becomes obliterated, and the remaining covering is then known as the tunica vaginalis. In the vast majority of patients with cryptorchidism, this sac remains patent, producing a clinical finding of inguinal hernia. Frequently a hydrocele is noted, too.

Incidence and Etiology

The incidence of cryptorchidism is about 3% of all 1-year-old males. The condition occurs most commonly on the right side, and in 10% of the cases is bilateral. Spontaneous descent is frequently delayed until the child is almost one year of age, so it is probably unwise to establish the diagnosis until that time. Also, examination is made best with the child in a standing position, something a one year old can usually accomplish.

Many theories have been advanced as to the etiology of this anomaly, but embryologists are as yet unsettled as to the actual cause. Two common findings at the time of repair are (1) shortened spermatic vessels and (2) fibrous adhesions about the testis. These, of course, might represent secondary rather than primary findings. In bilateral cryptorchidism, the endocrine factor is thought by most to be important.

An undescended testis may be found in one of several locations. The most common site is in the subcutaneous tissue overlying the inguinal canal near the external ring. The testis can be readily palpated in this position. Frequently it is still lying in the inguinal canal, and in this position palpation is difficult. By light palpation along the course of the inguinal canal, the testis can be located by a sense of firmness and some tenderness elicited on pressure. A slight bulge occasionally is evident, too. If a missing testis cannot be located in these two places, a search should be made of the surrounding area. Testes have been found in the subcutaneous tissue (readily palpable) at the base of the penis, in the femoral area, or in the perineum. There have been reports of both testes being located on one side. If all these locations fail to reveal the testicle, abdominal retention of the organ should be considered. It is unwise to assume the testis is absent; re-examination is indicated at a later date. If, after several examinations, the testis is not located, surgical exploration is indicated.

A differentiation occasionally has to be made between an undescended and a migrating testicle. The latter condition is the result of an overactive cremaster muscle reflex, which may move the testicle from the scrotum into the inguinal canal. Pressure applied over the canal will move the testis back into the scrotum and establish the diagnosis of a retracted testis. No therapy for this migrating testis is indicated since the condition is self-limited.

Clinical Studies

Clinical statistical investigations have been done by Gilbert and Hamilton, Campbell, Gordon–Taylor and Wyndham, and Friedman and Moore. In general, their statistics are in accord. The incidence of neoplastic change among patients with cryptorchidism is about 9%. Of the large series of testicular tumors reported, about 11% are from undescended testes. Patients with a testicular tumor and an undescended testis had the tumor in the undescended testicle in 97%

of the cases. Of interest, also, was the much higher incidence of neoplasm in abdominal cryptorchidism as compared to that in the inguinal type. The incidence of bilateral testicular tumors is reported more in undescended testes than in scrotal testes. Rusche and Kaplan and Roswit have recently reported neoplasms in patients with previous orchiopexies. Thus, authorities agree that orchiopexy at any age does not alter the incidence of neoplastic change.

At what age should therapy begin? The functions of the testicle must be considered in the complete evaluation of an ectopic testis. Recently, Sohval, Charny *et al.*, Moore, Robinson and Engle, and Hansen have enlightened us on the histological changes occurring in these patients. This information has served to stimulate a reappraisal of the problem. Many physicians have treated the bilateral types of cryptorchidism with three weeks of intensive hormonal therapy just prior to puberty and have followed this with surgery if no descent occurred. In the unilateral situation, hormones probably are not an etiological factor. Moore, using guinea pigs, produced cryptorchidism and found that spermatic elements were destroyed when the testicle was moved out of the scrotum, but would return to normal if the testicle was replaced before destruction was complete. Hansen, in 1949, and Rea, in 1951, reported evaluations in adults with repaired and unrepaired cryptorchidism by sperm counts; virtually all examined in both series were judged to be sterile.

Charny and his group biopsied 137 testicles on living subjects, and they noted that Leydig (androgen–producing) cells developed at the age of 10 and became abundant at the time of spermatozoan development, ages 11 to 15. The biopsies of surgically treated patients with cryptorchidism, ages 5 and over, showed normal Leydig cells but underdevelopment of the spermatic elements. The extent of the underdevelopment was felt to be sufficient to cause sterility in most cases.

Sohval made a comprehensive histological study of undescended testicles of 42 patients; and for comparison, scrotal testicles of 59 patients were studied. The patients varied in age from newborn to over 70. The findings were similar to those in the Charny group; namely, there is no apparent alteration in the development and number of Leydig cells in ectopic testes, but the differences arise in the spermatic elements. It appeared that in the prepuberal period the scrotal testes had a greater number of spermatogenic cells, and they were more advanced in development. At puberty, the ectopic testes showed a marked decrease in the number of sperm; and in the postpuberal period these testicles also showed degeneration of the seminal epithelium with fibrosis of the tubular and intertubular structures. Sohval suggests that malposition may not be the prime factor in these changes; but perhaps there is a congenital or constitutional inferiority present, which might explain the persistence of infertility in surgically repaired cases.

Robinson and Engle reported a study of 150 testicular biopsies made at the time of orchiopexy or following orchiopexy. These authors, too, found spermatogenic impairment in virtually all patients with cryptorchidism. They described five periods in the life of the testis: (1) prior to birth when it is under maternal influence; (2) birth to age 5, when there is no apparent change; (3) ages 5 to 10, when growth occurs; (4) ages 10 to 15, when maturity occurs; and (5) age 15 to death. They feel that therapy should be directed accordingly, before age 5 when growth begins. These authors also suggest that cryptorchidism may be an inherited anomaly, and even early repair may not solve the problem of infertility.

Management

From these studies, I believe certain conclusions can be drawn and various methods of management evolved.

The primary aim of all methods should be to bring the testis into the scrotum as soon as is practical so that the period of growth and development takes place in the normal environment of the scrotum where the temperature is lower. It should be accomplished before the child has reached the age of 5. This will probably afford the greatest protection against degeneration and atrophy of the spermatogenic elements. If surgery is required, it is wise to wait until after the patient is 4, when the larger size of the child aids the technical aspects of surgery. Watchful waiting until puberty in the hope that the testis will descend by itself is not recommended because the majority of patients will be sterile by that time. If presented with a unilateral cryptorchidism in a patient over the age of puberty, an orchiectomy might be the wisest choice.

Detailed surgical descriptions of the various methods of orchiopexy have been well presented many times and are not pertinent to this discussion. However, it is important to emphasize that every effort should be made to bring the testis into the scrotum in one operation. Two-stage procedures have been described; but because of the fibrous tissue reaction about the cord and testis, they have generally been avoided. Many times the testicular blood supply has to be freed high in the retroperitoneal space and perhaps rerouted more directly to the scrotum. If all such measures fail, an orchiectomy is generally preferable to leaving the testis elsewhere than in the scrotum.

Hormone therapy is indicated in two situations in this condition. It is used by many physicians just prior to orchiopexy because they feel that it produces congestion of the vascular supply, which causes lengthening and facilitates surgery. It is also indicated in bilateral cryptorchidism in which a hormone imbalance is suggested. In general, however, hormone therapy has been only moderately successful, and many physicians have discontinued its use. The hormone used is a follicular-stimulating type, chorionic gonadotropin. The use of testosterone is contraindicated as it does not stimulate growth, but will cause the anterior pituitary to decrease its output of follicular-stimulating hormone, with resulting lack of testicular growth. Prolonged administration of gonadotropic hormone is also contraindicated because the androgen produced by the stimulation promotes premature secondary sexual changes.

In general, surgical repair or removal is necessary in the majority of patients with cryptorchidism. In addition to the reasons discussed above, the high incidence of associated indirect inguinal hernia makes surgery necessary. A truss is definitely contraindicated as the pressure would be injurious to the testis. There are other complications, the possibility of which surgery would eliminate. Torsion occurs commonly in malpositioned testes and, if it does occur, markedly decreases any hope of preserving a normal testis, even if saved and repaired at a later date. The cosmetic value of an orchiopexy varies, of course, with each individual patient; but, in general, children of school age are quite sensitive to any anatomical differences between themselves and others, so the amount of psychic trauma may be considerable in a sensitive child.

Postoperative or posthormonal management consists of watchful waiting in the form of yearly check-ups. Atrophy and malignant degeneration are the two untoward developments that the physician should be alert for. In bilateral cryptorchidism, a sperm count should be performed to evaluate the degree of sterility.

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REFERENCES

1. Campbell, H. E.: Incidence of malignant growth of undescended testicle; critical and statistical study, Arch. Surg. 44:353–369 (Feb.) 1942.
2. Campbell, M.: Clinical Pediatric Urology, Philadelphia and London, W. B. Saunders Company, 1951.
3. Charny, C. W., Conston, A. S., and Meranze, D. R.: Development of testis; histologic study from birth to maturity with some notes on abnormal variations, Fertil. & Steril. 3:461–479 (Nov.-Dec.) 1952.
4. Dixon, F. J., and Moore, R. A.: Tumors of Male Sex Organs. Washington, D. C., Armed Forces Institute of Pathology, 1952.
5. Friedman, N. B., and Moore, R. A.: Tumors of testis; report on 922 cases, Mil. Surgeon 99:573-593 (Nov.) 1946.
6. Gilbert, J. B.: Studies in malignant testis tumors; tumors developing after orchidopexy; report of 2 cases and review of 63, J. Urol. 46:740–747 (Oct.) 1941.
7. Gilbert, J. B., and Hamilton, J. B.: Studies in malignant testis tumors: incidence and nature of tumors in ectopic testes, Surg., Gynec. & Obst. 71:731–743 (Dec.) 1940.
8. Gordon-Taylor, G., and Wyndham, N. R.: On malignant tumours of testicles (Skinner lecture, abridged), Brit. J. Surg. 35:6–17 (July) 1947.
9. Grove, J. S.: Cryptorchid problem, J. Urol. 71:-735–741 (June) 1954.
10. Hansen, T. S.: Fertility in operatively treated and untreated cryptorchidism, Proc. Roy. Soc. Med. 42:645–651 (Sept.) 1949.
11. Kaplan, G., and Roswit, B.: Bilateral testicular tumors following bilateral orchiopexy, J.A.M.A. 144:1557–1558 (Dec. 30) 1950.
12. Moore, C. R.: Experimental studies on male reproductive system, J. Urol. 65:497–506 (April) 1951.
13. Rea, C. E.: Fertility in cryptorchids, Minnesota Med. 34:216–217 (March) 1951.
14. Robinson, J. N., and Engle, E. T.: Some observations on cryptorchid testis, J. Urol. 71:726–734 (June) 1954.
15. Rusche, C.: Testicular tumors: clinical data on 131 cases, J. Urol. 68:340–353 (July) 1952.
16. Sohval, A. R.: Histopathology of cryptorchidism; study based upon comparative histology of retained and scrotal testes from birth to maturity, Am. J. Med. 16:346–362 (March) 1954.
17. Sohval, A. R.: Testicular dysgenesis as etiologic factor in cryptorchidism, J. Urol. 72:693–702 (Oct.) 1954.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: J. F. Kuzma, M. D.

Presentation of Case*

THIS 36-year-old white male was known to have had a normal blood pressure upon discharge from the armed forces in 1946. He was first told that he had high blood pressure in 1948 and then again in 1952. Because of increasingly severe headaches he was admitted to a Madison hospital in August, 1952, where a blood pressure of 210/140 was noted. A hypertensive work-up revealed a Grade III retinopathy; but a urinalysis, phenolsulfonphthalein test, nonprotein nitrogen determination, intravenous pyelogram, chest x-ray, and electrocardiogram were all normal. Cold pressor, Benzodioxane, and Regitine tests showed no significant changes. He had an average pressure of 180/120 while taking Methium and was discharged with instructions to take 1,750 mg. daily. The patient developed severe constipation in November, 1952, and discontinued his medication.

He was admitted here for the first time in March, 1953, with weakness, vomiting, and occipital headaches. The blood pressure was 210/160 in the upper extremities and 235/180 in the lower, but the patient still had a Grade III hypertensive retinopathy. The chest x-ray showed no cardiac enlargement. The skin color was described as good. The history revealed that an aunt had hypertension and that one brother had died at the age of 39 of a "heart attack." No history suggestive of previous kidney trouble could be elicited.

Laboratory Data: Complete blood count and sedimentation rate were normal. Urinalysis revealed a trace of albumin, an occasional granular cast, and 1 to 2 red blood cells. A phenolsulfonphthalein test, nonprotein nitrogen determination, and blood urea nitrogen determination were normal. Urea clearance showed 88% of average normal clearance. Addis count revealed definite elevation in red blood cells, white blood cells, and granular casts. A glucose tolerance test showed a diabetic type curve.

The patient was started on Apresoline and Methium, but with good dosages the pressure remained elevated.

First Admission: In March, 1953, the patient had a bilateral lumbodorsal sympathectomy, and both adrenal areas were normal to palpation. He was discharged on July 13, 1953, essentially asymptomatic and with an average standing pressure of 210/120.

Second Admission: The patient was readmitted on Aug. 26, 1953, because of weakness, palpitation, and faintness. His blood pressure remained persistently elevated, and the pulse rate varied from 110 to 130. He developed a moderate anemia that was thought to be a manifestation of renal failure. This conclusion was reached after no evidence of external bleeding, hemolysis, or marrow changes was found. The nonprotein nitrogen varied from 44 to 65 mg.% during the patient's last admission. On Sept. 20, 1953, he experienced a "choking" anterior chest pain that was accompanied by diaphoresis and nausea. An electrocardiogram showed no recent changes, but a chest x-ray showed pneumonia in the right central and lower lung fields. The patient was treated with antibiotics and Dicumarol was added since possibly this episode represented a pulmonary infarct. He improved temporarily but then became more dyspneic, developed Cheyne–Stokes respiration, and expired on Sept. 29, 1953.

Dr. Howard L. Correll, Consultant in Internal Medicine: This 36-year-old white male had no history of hypertension at the time of his discharge from the armed forces in 1946. This excludes one of the secondary causes of hypertension which must always be considered in younger individuals; namely,

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coarctation of the aorta. Good pulsations in the arteries of the abdomen and lower extremities and a blood pressure reading which was 20 points higher both systolic and diastolic than it was in the upper extremities also excludes coarctation. The blood pressure normally is up to 20 mm. mercury higher in the lower extremities than it is in the upper extremities because of the larger size of the vessels compressed by the cuff. This is reversed in coarctation.

When the patient first became ill, the urine, intravenous pyelogram, electrocardiogram, and x-rays for heart size were normal. There was no evidence of unilateral renal disease or of renal or suprarenal malignancy to suggest a secondary hypertension. Up to the point of the admission at the Madison hospital this condition would have to be considered either essential hypertension or secondary hypertension unassociated with renal disease producing abnormal urinary sediment. Chromaffin tumor or the various collagen diseases that are associated with hypertension, particularly polyarteritis, would have to be considered. The cold pressor test was reported to have been normal. This test is ordinarily normal in chromaffin tumors but is apt to be abnormal in essential hypertension. The Benzodioxane and Regitine tests were apparently done at Madison and were normal. Normal results in these tests do not rule out chromaffin tumor, however. There are about 10% false negative tests. The patient was given Methium without response. He evidently discontinued the medication himself because of the severe constipation which resulted; this is a common complication of Methium therapy. He became worse and was admitted to this hospital.

Again, one of the striking things in view of the symptoms and the appreciable hypertension was the fact that there was no evidence of cardiac enlargement. The electrocardiograms showed only some early changes suggesting left ventricular hypertrophy.

The laboratory work-up in this hospital again tended to eliminate serious consideration of nephritis and pyelonephritis. There was an increase in the red blood cells, white blood cells, and casts on Addis count; but it was hardly sufficient to make one think the severe hypertension and rapid course here presented were from that cause. One pertinent laboratory finding is the diabetic glucose tolerance curve. This, added to the negative cold pressor test, supports the idea of a possible chromaffin tumor with a fixed rather than fluctuating hypertension. An elevated basal metabolism would have been further laboratory support for this contention.

From a clinical standpoint, if one could get a history of persistent tachycardia, bouts of fever, extreme diaphoresis, and reddening and blanching of the skin, he would be most suspicious of a chromaffin tumor.

On physical examination there is paroxysmal or fixed elevation of the blood pressure; occasionally palpation and massage of the renal areas may cause a sharp increase in the hypertension from release of the pressor amines into the circulation. Sometimes a postural hypotension is noted, often associated with tachycardia. As already stated, the cold pressor test is apt to be normal. In the presence of hypertension the Regitine test will usually give a positive response, a fall in blood pressure of more than 25 mm. systolic and more than 20 mm. diastolic being positive. A histamine test in a patient with persistent hypertension would not be used. The intravenous pyelogram may reveal some displacement of the kidney, most often on the right. Pararenal or parasacral air insufflations may outline a tumor mass. Recently, a test of the urinary catechol amines has been found helpful in establishing the diagnosis of chromaffin tumor. I doubt that it was done in this case.

At the time of the patient's admission to the hospital, apparently a chromaffin tumor was one of the things that was being considered in the differential diagnosis. One would also consider a fairly severe essential hypertension. Another possibility which can give similar clinical findings and the elevated glucose tolerance curve is one of the collagen diseases, particularly polyarteritis. I presume that was a consideration at the time. In any event, the patient underwent a bilateral lumbodorsal sympathectomy; and at the time of surgery the adrenals were palpated. No chromaffin tumor or any other tumor in the renal area was palpated.

Following surgery, the patient's course was progressively downhill. He was readmitted with complaints of weakness, palpitation (tachycardia, I presume) and episodes of faintness. We don't know whether he had diaphoresis. Apparently he was not febrile at any time during his course in the

hospital. He had developed a moderate anemia which was felt to be a manifestation of renal failure, though there was little evidence of such failure. The nonprotein nitrogen varied from 44 to 65 mg.% and might have been due to dehydration. During this period in the hospital he developed choking anterior chest pain. Again there was no fever during this episode of chest pain. With the chest pain he developed pneumonia in the right lobe of the lung.

How can one explain such findings in the absence of fever? The patient could have had a myocardial infarction. The electrocardiogram shows no evidence of this, nor do serial tracings show progressive changes. This would be very unusual if recent infarction was present. It is not unusual to find an absence of typical changes of myocardial infarction, but it is unusual to have repeatedly normal tracings with recent infarction.

Dissecting aneurysm would have to be considered as a possibility. The things that are against this diagnosis are: 1. the findings in the right base in the lung and 2. the absence of any pulse changes. If the dissection obstructs any of the vessels leading out of the aorta, the pulse in that particular extremity will be reduced or absent. If visceral arteries are obstructed, there will be signs of infarction of the involved viscera.

Pulmonary infarction or pneumonia was apparently considered. Both should have been associated with some fever. There was no fever in this instance.

Could these be the pulmonary changes that occur with uremia? Such changes are usually bilateral and mainly hilar, fanning out laterally. This does not seem to be the explanation.

Could the collagen diseases be a possible explanation? Certainly polyarteritis, particularly the type some people term hypersensitivity angiitis, may involve the lungs. It is usually a rather acute form of disease and wouldn't be apt to explain hypertension of this duration. True periarteritis nodosum, not the hypersensitivity angiitis, is ordinarily not associated with pulmonary lesions and, therefore, is excluded. I can't explain the right pulmonary lesion and the chest pain.

To explain the entire picture, there are then three possibilities. One is chromaffin tumor, despite failure to find a tumor on surgical exploration. The second possibility is a collagen disease, specifically polyarteritis.

Fig. 1—Photograph of adrenal gland with tumor, showing dark colored, sharply circumscribed, centrally located mass in the upper one-half of the specimen.

The diabetic glucose curve, the long-standing hypertension, the progressive involvement of the heart, and the involvement of the kidneys would all fit a diagnosis of polyarteritis. Pulmonary lesions in polyarteritis, as I said, are unusual. In this instance the pulmonary lesion would have to be uremic and associated with renal polyarteritis. The third possibility is essential hypertension with a rather rapid deterioration. One would have to assume some local pulmonary disease, which I can't place, as also present. I would say the most likely possibility in this instance would be a chromaffin tumor for the reasons stated. The second most likely possibility would be periarteritis nodosum with uremic pulmonary changes.

Question: Would you consider primary amyloidosis?

Doctor Correll: The picture does not fit primary amyloidosis.

Dr. Joseph F. Kuzma, Consultant in Pathology: Thank you, Doctor Correll. It is indeed a pleasure to be here and to present to you some of the pathologic findings of this case.

This patient had the following course of events, in reverse chronological order. He expired with a combination of cardiac failure and pulmonary edema. This was associated with malignant hypertension, which in turn was associated with an adrenal medullary tumor. The x-ray changes of the lungs, as

Doctor Correll has discussed, may be explained on the basis of moderate azotemia and edema. A good percentage of azotemic patients show anatomic pulmonary changes which consist of interstitial edema, interstitial cellular infiltrations, and hyaline membrane changes. Hyaline membrane pulmonary changes may also be associated with malignant hypertension, especially when there are focal hemorrhages present in the lungs. The malignant hypertension complex that this patient had was associated with the presence of a pheochromocytoma of the right adrenal gland. This tumor is perhaps a little more common in the right adrenal gland than in the left and is located in the center since it is derived from the medullary sympathetic tissue.

In figure 1 you can see the normal part of the adrenal gland represented by a thin yellow cortex which is stretched over the dark tumor mass located centrally. Histologic sections of the tumor show the comparison between normal compact adrenal cortex and the tumor, which has a very loose, spongy architecture. A closer look at the tumor shows an extremely vascular framework, upon which are attached large polyhedral cells with an eosinophilic cytoplasm occasionally stippled by the presence of dark brown granules (fig. 2). Nuclei vary in size and shape. The loose, spongy, vascular pattern of large eosinophilic polyhedral cells with great variations in size and outline is the characteristic architecture of this tumor. The kidney presented petechial and confluent petechial hemorrhages of the mucous membranes and cortex. These changes are usual for many vascular diseases but perhaps most prominent in malignant hypertension. The histologic changes of the kidneys were those of arteriolonecrosis and glomerular thrombonecrosis, which is so characteristic of malignant hypertension (fig. 3).

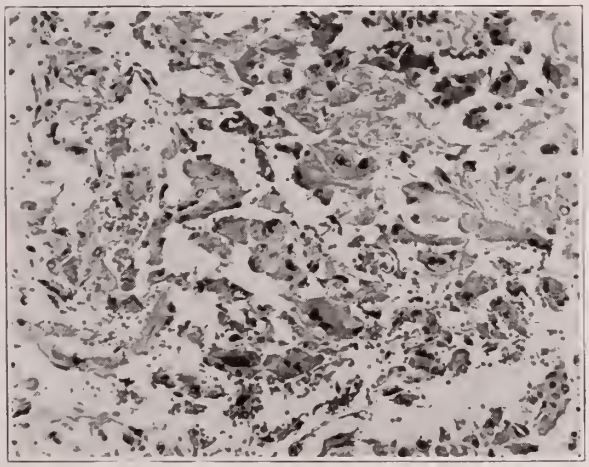

Fig. 2—High-power magnification of the adrenal tumor showing numerous red blood cells and the large polyhedral pointed and tailed chromaffin cells.

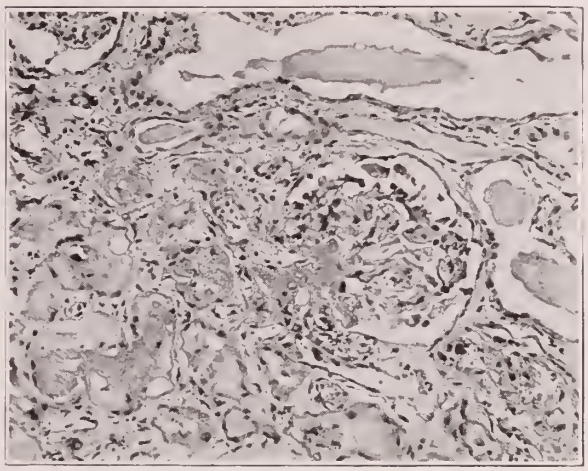

Fig. 3—Photomicrograph of kidney, showing arteriolar necrosis and tubular atrophy of the kidney.

The pheochromocytoma is so named because of its dark color (pheo—dark). It has cytoplasmic granules, which have great reducing powers. In the presence of salts of chromic acid, these granules become dark brown. Therefore, such medullary tumors should be fixed in a chromate solution to best show the presence of the granules. The tumor secretes an epinephrine or norepinephrine substance which reduces the chromic acid salts. Not all cells show this brown granule development; but, with proper fixation, total absence of granules is a strong indication that the tumor is not a pheochromocytoma. The norepinephrine produced by such tumors is secreted into the blood vascular system and produces an adrenalin-like effect; namely, hypertension, palpitation, etc. It is very interesting that in this case the tumor was suspected and tests to show its presence were performed and exploratory surgery done, but all these were negative. The interpretation of tests is discussed in several reports, a recent one being "Pheochromocytoma: The Value of Certain Tests Used Routinely in Diagnosis" by Edward S. Orgain.[1]

Small tumors are usually soft in consistency, whereas the larger ones, and particularly those with hemorrhage, become a bit

more firm and more easy to palpate. The tumor is bilateral in approximately 20% of the cases, and this is important to remember for on surgical exploration the removal of one adrenal with tumor may not correct the hypertension if there is another on the opposite side or if there is additional tumor tissue in the neighborhood of the adrenals. Perhaps 1 or 2% of such tumors are malignant and, when malignant, are usually "nonfunctional."

Question: How rapidly do you expect such a tumor to increase in size?

Doctor Kuzma: I have no idea how one can assess the rapidity of growth of such a lesion. Some patients with tumors which are less than 2 cm. in diameter do not have remarkable hypertension whereas those with larger tumors usually do. It is unknown how long the tumor may exist before clinical findings become evident. I know of no correlation between the size of the tumor and the duration of symptoms. In many instances the hypertension is paroxysmal for a long time, yet the tumor is no larger than walnut size. On the other hand, just the other day I saw a bilateral adrenal pheochromocytoma with accessory nodules outside of one adrenal gland in a patient who apparently had had no symptoms until her recent pregnancy, during which she expired with cerebral hemorrhage.

Doctor B. H. Dessel: Was surgery done at another hospital?

Doctor H. D. Rose: Surgery was done here.

Doctor Dessel: What was the anesthesia report?

Doctor Rose: No suggestive findings.

Question: How frequently do these tumors occur?

Doctor Kuzma: Perhaps three hundred of these tumors located in the adrenal gland have been reported. There are also many related tumors without reducing properties in respect to chromic acid salts; and these are called paragangliomas, carotid body tumors, etc.

Question: How common is choking and chest pain in a patient with heart failure and edema?

Doctor Correll: That is hard to answer. The patient may have experienced an entirely different form of pain. He may have suffered from choking sensations of active heart failure, or he may not have had any pain at all. The choking may have been his inability to get breath. This is not uncommon in left heart disease.

Doctor Kuzma: I did not mention that the patient had a myocardial infarct which was located in the lateral wall of the left ventricle. It was a very old lesion and had no relationship to the terminal episode. The coronary arteries showed an advanced degree of sclerosis.

REFERENCE

1. Orgain, E. S.: Pheochromocytoma: value of certain tests used routinely in diagnosis, Ann. Int. Med. 43:1178–1194 (Dec.) 1955.

OTOLARYNGOLOGY MEETING

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from October 1 through 7, 1956. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose, and throat.

Interested physicians should write to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Resuscitation of the Newborn Infant

Successful resuscitation of the newborn infant continues to be one of the very serious problems and responsibilities of both the obstetrician and anesthesiologist. The death rate associated with birth and the immediate neonatal period has not been decreased in spite of great strides in the reduction of general pediatric mortality. Over 150,000 infants die annually in the United States at birth.[1, 2] Death in 59% of this number is due to anoxia and abnormal pulmonary pathology. Anoxia in the newborn infant is responsible, too, for permanent disability or mental retardation.[3]

Description—Asphyxia Neonatorum Syndrome

Asphyxia neonatorum is primarily a state of oxygen lack. Several classifications of the syndrome have appeared in the literature, but the classification of Flagg describes the degree of oxygen lack in meaningful terms for the clinician faced with the problem.[4, 5] He distinguishes a stage of depression, a stage of spasticity, and a stage of flaccidity. The infant in a state of depression does not breathe well and has recurrent cyanosis and duskiness. The vital centers and reflexes are depressed from anoxemia, but they are stimulated easily to normal activity. Irregular, gasping, shallow respirations with long intervals of apnea are seen in the stage of spasticity. Cyanosis is marked. Active pharyngeal and glottic reflexes are present. One must remember that the normal infant has some muscle tone and that spasticity alone is not necessarily a sign of asphyxiation.[6] In the flaccid stage respirations are very shallow or absent and the infant is cyanotic or extremely pallid. There is complete flaccidity of all muscles with a markedly relaxed jaw. Reflexes are absent, fluid is usually present in the hypopharynx, and the circulation is failing.

The fundamental pathological lesion is complete atelectasis of the lungs. Asphyxia also produces congestion of the blood vessels which, if severe, results in interstitial edema and subsequent hemorrhages in the lungs, the liver, the gastrointestinal tract, and the brain. A final stage is one of irreparable tissue damage.[5]

Certain chemical phenomena occur in the blood of the asphyxiated newborn infant. Eastman's studies indicate that the syndrome is one of chemical imbalance characterized by decrease in the concentration of oxygen, an increased tension of carbon dioxide, marked increase in lactic acid, and a decrease in the hydrogen ion concentration of the fetal blood.[7]

Factors Affecting Incidence

Prevention of the syndrome is partially dependent upon thorough understanding of the circumstances under which asphyxia is likely to occur. Not all instances will be preventable, but certain situations can be avoided by adequate prepartum care and labor management.

Maternal factors include age of the mother, parity, and general health. Incidence of asphyxia increases markedly after the age of 40. Primiparas give birth to asphyxiated infants more frequently than multiparas until after the eighth baby. Health is also important, with respiratory and circulatory diseases, abnormal metabolic states, and toxemias increasing the incidence.

The viability of the germ plasm and the development of fetal disease or congenital anomalies may be of importance. Prematurity constitutes the most significant single factor.[5] These infants are especially prone to depression by analgesic or anesthetic drugs, and the combination is often disastrous. Hypotension during any form of conduction anesthesia must be avoided.

Conduct of labor and delivery is of utmost importance. Long, difficult labors; use of oxytocic drugs; complications of labor such as prolapsed cord, placental insufficiency, and operative deliveries such as version and extraction, breech, and midforceps are factors increasing the possibility of asphyxia.

The analgesic drugs and anesthetic agents used during labor are frequent factors involved in the production of fetal asphyxia. All forms of analgesia and anesthesia increase the incidence. Attention must be directed not only toward the comfort of the mother but to the welfare of the undelivered baby. Judicious use of all forms of pain relief is mandatory.

The incidence of asphyxia is higher following Cesarean section than after pelvic deliveries. Delayed respiratory distress seen in many of the infants is due to vomiting and aspiration of ingested amniotic fluid. Immediate gastric aspiration as a routine procedure has resulted in 50% reduction of fetal mortality after Cesarean section.[5] Apgar and her group recommend gastric aspiration on every baby as a means of ruling out congenital anomalies of the esophagus, particularly tracheo-esophageal fistulae, as well as preventing delayed aspiration.[6]

Resuscitative Procedure

Preparedness is the keynote of all resuscitative technique. The importance of having available well-trained personnel and suitable equipment cannot be overemphasized.[8] The objectives of resuscitation are threefold: (1) speed—seconds count in the prevention of brain damage; (2) simplicity—complex apparatus and techniques interfere with quick resuscitation; and (3) gentleness at all times in the handling of the infant. Techniques must vary according to whether one requires methods for initiating breathing or needs methods for supplementing the infant's own efforts during respiratory distress.[9]

The establishment and maintenance of a patent airway is of prime importance. Gentle aspiration of the nose, mouth, and pharynx and, if necessary, the tracheobronchial tree, must be done immediately. Placement of the infant in a slightly head-down position, 15 to 30 degree Trendelenburg, facilitates drainage. A flaccid infant should be intubated to insure airway patency. Intubation must be done by competent personnel. Cutaneous stimulation such as gentle friction and passive movements of the extremities may aid in the initiation of respiration. Vigorous spanking, hot and cold tubbing, jack-knifing, hanging by the heels, and other strenuous methods are condemned.

If the infant does not respond immediately to the establishment of a clear airway and gentle stimulation, oxygen should be administered without hesitation. The oxygen content of fetal blood is reduced to very low levels, and irreversible damage from hypoxia can occur with minutes of delay. Carbon dioxide should not be administered under any circumstance. In concentrations above 10%, the gas is anesthetic and, used in states of severe oxygen want, even lower concentration of the gas may be depressant to the infant's respiratory center.

The fundamental problem in resuscitation is to produce expansion of the lungs. When the newborn infant remains apneic, some method of artificial respiration must be utilized to overcome atelectasis. Expansion of the lungs can be secured by intermittent, short, sharp "puffs" of positive pressures. A completely satisfactory method has not yet been devised, and the danger of pulmonary damage does exist with all methods. However, it is better to have a live patient with ruptured alveoli in preference to a dead one with intact alveoli.[3]

The infant should be kept warm with blankets or an incubator. Care should be taken not to raise temperatures too high or too rapidly. The normal temperature for a full-term infant is 93° F.[6]

Analeptic drugs have no place in resuscitation. There is no known drug that will initiate respiratory activity that has ceased. All stimulant drugs increase metabolic rate and increase oxygen requirements, adding to the damaging effect of hypoxia. Often a more severe depression results. In the case of definite opiate overdose as the cause of the asphyxiation, Nalline (N–allylnormorphine hydrochloride) has worked in 75% of the cases.[6]

Asphyxia neonatorum can be prevented in many cases by adequate and careful prenatal care and labor management. When resuscitation is necessary, establishment of a patent airway, oxygenation, and gentle handling of the infant are essential. Stimulant drugs should not be used. All delivery rooms should be equipped with oxygen, suction, some method of positive pressure, and endotracheal equipment.

REFERENCES

1. Goddard, R. F.: Role of infant resuscitation team in investigative studies of respiratory onset at birth, Anesth. & Analg. 34:1–25 (Jan.–Feb.) 1955.
2. Cohen, E. N.: Resuscitation of newborn, Minnesota Med. 35:750–752 (Aug.) 1952.

3. Murphy, R. A.: Resuscitation of newborn. J. M. Soc. New Jersey 52:135–137 (March) 1955.
4. Flagg, P. J.: Treatment of postnatal asphyxia, Am. J. Obst. & Gynec. 21:537–541 (April) 1931.
5. Little, D. M., Jr., Hampton, L. J., and White, M. L.: Asphyxia neonatorum: syndrome, its prevention and its treatment, Anesthesiology 13:518–539 (Sept.) 1952.
6. Apgar, V.: Proposal for new method of evaluation of newborn infant, Anesth. & Analg. 32:260–267 (July–Aug.) 1953.
7. Eastman, N. J.: Foetal blood studies; chemical nature of asphyxia neonatorum and its bearing on certain practical problems, Bull. Johns Hopkins Hosp. 50:39–50 (Jan.) 1932.
8. Cappe, B. E., and Pallin, I. M.: Practical aspects of resuscitation of newborn, New York J. Med. 51: 1797–1800 (Aug. 1) 1951.
9. Bannister, W. K., and Little, D. M.: Physiological Treatment of Asphyxia Neonatorum, Scientific Exhibit, A.M.A. 105th Annual Meeting, Chicago, June 11–15, 1956.

INTERNATIONAL CANCER CYTOLOGY CONGRESS

The first International Cancer Cytology Congress, sponsored jointly by the International Union Against Cancer, the College of American Pathologists, the American Society of Clinical Pathologists, and the Inter-Society Cytology Council, will be held at the Drake Hotel, Chicago, on October 9, 10, and 11, 1956.

SCIENTIFIC PROGRAM

TUESDAY, OCTOBER 9

Chairman: Charles S. Cameron, New York — MORNING

The Historical Landmark in Exfoliative Cytology	George N. Papanicolaou, New York
The Present-Day Scope of Clinical Cytology	John B. Hazard, Cleveland
Structure of the Fixed and Stained Cell	Isadore Gersh, Chicago
Possibly Distinctive Properties of Malignant Cells	E. V. Cowdry, St. Louis
Normal Cells Originating in Respiratory Tract	Eileen King, San Francisco
Pulmonary Cancers and Their Cells: A Study of Sputum	John B. McDonald and Lewis B. Woolner, Rochester, Minn.
Pulmonary Cancers and Their Cells: A Study of Bronchial Washings	Nathan Chandler Foot, New York

Chairman: David A. Wood, San Francisca — AFTERNOON

The Cellular Content of Effusions Not Related to Cancer	Sarah Luse, St. Louis
Recognition of Malignant Tumor Cells in Effusions	Otto Saphir, Chicago
The Cellular Detection of Carcinoma of the Esophagus	F. Thomas Gephart, Boston
Normal and Abnormal Cells in Gastric Washings	John Seybolt, New York
The Cellular Detection of Cancers Involving Urinary Tract	Walter T. Wikle, Denver
A Pathologist's Views on the Subject of Cytology	David C. Dahlin, Rochester, Minn.

Panel Discussion: Aspiration Biopsy

WEDNESDAY, OCTOBER 10

Chairman: Lewis C. Scheffey, Philadelphio — MORNING

Problems in Mass Screening	Cyrus C. Erickson, Memphis
The Automatic Scanner	Walter E. Tolles, Mineola, N. Y.
Normal Cells Arising in the Female Genital Tract	Charlotte M. Street, New York
Metaplasia of the Uterine Cervix	Hugh F. McCorkle, Cleveland
Atypia of the Uterine Cervix and Its Relation to Trichomoniasis	T. R. Simon, L. G. Koss, and Wanda Wolinska, New York
"Pre-Cancerous" Changes in the Uterine Cervix	Edward E. Siegler, Cleveland

Panel Discussion: Problems in Confirming Cellular Evidence of Cancer

Chairman: Osbarne A. Brines, Detroit — AFTERNOON

Cellular Changes Simulating Those of Cancer	Ruth M. Graham, Boston
Cellular Study of Epithelial Dysplasia in Pregnancy	William D. Walters, Detroit
Squamous Cell Cancer of the Uterine Cervix: A Histo-Cytological Study	J. L. McCormack, Cleveland
The Cellular Detection of Uterine Adenocarcinoma	John Berg and Grace R. Durfee, New York

Panel Discussian: Prognosis in Cancer of the Uterine Cervix as Determined by Histologic and Cytologic Methods

THURSDAY, OCTOBER 11

Chairman: Emerson Day, New York — MORNING

New Advances in Cytology (papers to be selected)

Chairman: James B. McNaught, Denver — AFTERNOON

Symposium: Carcinoma in Situ of the Uterine Cervix

For specific information concerning the Congress, write Dr. Arthur H. Dearing, College of American Pathologists, Prudential Plaza, Suite 2115, Chicago 1, Illinois.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Symptomatic Therapy of Pollinotic Rhinitis

The union of pollen (antigen) with antibody in or on the cells of the mucous membranes of the upper respiratory tract results in the liberation of histamine, acetylcholine, and other less well-defined materials. These substances, acting locally, result in edema, hyperemia, and an increased production of mucus. It is this series of events which results in the symptom-sign complex of allergic rhinitis.

Drugs used in treating allergic rhinitis must be evaluated on the basis of their capacity not only to alleviate the manifestations, but also to prevent the deteriorative progression of the disease to asthma and sinusitis. This is an important consideration inasmuch as approximately 50% of untreated pollinotic patients eventually develop clinical asthma. Properly carried out, preseasonal or perennial hyposensitization by injection should provide relief for about 80% of individuals affected with allergic rhinitis and prevent the subsequent development of asthma and sinusitis in an even larger group. Coseasonal treatment of this type is so inferior that its use is rarely indicated.

In the table, the drugs presently in use for symptomatic treatment are listed and compared with the specific method of therapy; namely, preseasonal hyposensitization. These drugs are by themselves quite effective. Within the past year prednisone and prednisolone were employed for the first time for symptomatic management of allergic rhinitis. These agents have been prescribed in doses ranging from 10 to 40 mg. per day for suppression of symptoms and from 5 to 20 mg. (average 10 mg.) per day for maintenance. Excellent results with minimal side effects have been reported; but the safety of these drugs, as well as their long-range effects, remains to be determined.

That symptomatic therapy has a place in the treatment of allergic rhinitis is well established; but it should be used in addition to, not in place of, specific therapy since the prevention of asthma and sinusitis is most important. Such a combination of specific antigen and drug therapy also provides summative symptomatic benefit.—SEYMOUR B. CREPEA, M. D.

Relative Effectiveness of Drugs in the Symptom Complex of Allergic Rhinitis

Drug	Action	Effectiveness	Side Effects	Prevention of Clinical Asthma and Sinusitis
Antihistamines	Block action of histamine	+++	Drowsiness; dryness of mucous membrane	None
Atropine	Blocks action of acetylcholine	++	Dryness of mucous membrane; inspissation of mucus	None
Oral Ephedrine	Reverses action of histamine	++	Nervousness	None
Prednisone or Prednisolone	Presumably anti-inflammatory	+++ to ++++	Cushing-like syndrome	Undetermined
Local Ephedrine, Neo-Synephrine, or Privine	Reduces edema of mucous membrane	++++ Short duration	Rebound reaction	None
Local Steroids	Anti-inflammatory	+	None	None
Specific Pollen	Increases clinical tolerance to antigen	+++ to ++++	Anaphylactic reactions due to overdosage	++++

A Look Into the Future at Lake Tomahawk State Camp

As It Looks to Your State Board of Health

DURING the past 41 years, Lake Tomahawk State Camp, on beautiful Lake Tomahawk in the heart of Wisconsin's northwoods, has served almost 1,700 patients convalescing from tuberculosis exclusively, for the purpose of physical hardening and rehabilitation.

In 1954 its population reached a peak of 69 patients at one time. Today it is operating at slightly more than two-thirds its capacity. The treatment of tuberculosis, both surgically and medically, has reduced the length of sanatorium care and likewise reduced such problems as the individual's need for making complete change of vocation or lengthy physical hardening procedures. As a result, the State Board of Health is now considering recommending to the legislature the admission of individuals with other disabling handicaps to utilize the facility to full capacity.

Today there is a tremendous enthusiasm for the establishment of such general rehabilitation centers. It is easy for the public to see the need and a chance to reduce social and economic costs of the dependency of the disabled. In 1954, Congress passed legislation to assist in the construction and expansion of rehabilitation centers throughout the country. There is a nationwide enthusiasm for such projects. The program is glamorous and easy to sell.

The first reaction to the suggestion that people with disabilities other than tuberculosis be accepted at Lake Tomahawk created great interest. It was soon discovered that numerous difficult problems exist which must be considered prior to making a definite move. What type of center should be developed? What disability groups should be served? Should physical restoration, physiotherapy, and reconditioning be part of the plan? Should training for vocations be widespread or limited to certain specific areas? What age groups should be served? How should standards of eligibility be established? Who is to pay for the services?

These and many other questions must be answered prior to the development of a program for a general rehabilitation center.

It has been found, through nationwide surveys, that the large majority of patients do not personally pay for rehabilitation center services. They are paid for by state agencies, voluntary health groups, private organizations, workmen's compensation, insurance carriers, community chests, and others. Certainly, the group paying for the services should have an active part in planning.

Lake Tomahawk enjoys a close agency relationship with many public and private groups. Although operated by the State Board of Health, the State Department of Vocational and Adult Education, through its rehabilitation division and vocational schools, provides services to the patients. The State Welfare Department, through its organization and county affiliates, helps in planning for the care of families of individuals at camp. The schools assist in training patients for future employment. The Wisconsin Anti-Tuberculosis Association makes contacts state-wide in behalf of the camp and its patients. The State Employment Service cooperates in placement. Many other agencies and individuals work to coordinate the present program. It is expected that they will not only continue their cooperation and interest, but will enthusiastically help in the planning for an expanded service.

There is a need for medical direction in planning and operating a center, even though the comprehensive service includes vocational evaluation, tryout, and training. A heavy emphasis must be placed on medical services. This has been proved at Lake Tomahawk State Camp and will continue to be an important consideration in its future plans. Sound medical evaluation in terms of work capacity and consideration of the possibility of removing or reducing the handicaps is imperative.

By trying to achieve the concept of total rehabilitation, including the medical, vocational, social, and economic phases, an expanded program at Lake Tomahawk to include individuals with other physical handicaps should prove to be sound business. —LEONARD HEISE, *Director, Lake Tomahawk State Camp.*

. . . . THE PRESIDENT'S PAGE . . . .

"Neither Pensions, Pity, Nor Parades"

WHEN I was in Chicago at the A.M.A. Annual Meeting, I listened to an inspiring address by the president of a manufacturing plant on Long Island. He hires only people who are so physically disabled they can't get a job anywhere else. The top foreman works from a wheel chair. Others have lost arms or legs; some are blind or deaf or both. They want no sympathy; they want only a chance to work and make an honest living. No government handouts for them. They have been rehabilitated and are doing very well, thank you, in the production of highly technical electronic equipment.

The name of the company: Abilities, Incorporated. The president: A man born without limbs.

This man spoke at a meeting of state medical society presidents and other officers shortly after his appearance before the Senate Finance Committee in opposition to lowering the eligibility age for social security to 50 for totally and permanently disabled people. His position becomes all the more amazing because every one of his 169 employees could qualify for permanent disability under terms of the proposed law.

This man had one important message: "There are no disabled veterans and there are no disabled people—only people. Neither pensions, pity, nor parades are adequate substitutes for the sweet dignity of a productive life."

His talk made me think of the so-called "unfortunates" in my own practice. One paralyzed since childhood from the waist down has had no trouble. He used his arms to get where he wanted to go. He married a girl who had suffered a polio attack but was less paralyzed than he. He supported himself as a jeweler and by serving as village clerk.

But there is another patient who had but a slight injury to his arm some months ago; he has already collected more than $1,000 from an insurance company and, though his arm motion is good, has refused an insurance company offer of an additional 5% disability. He wants more.

You all could cite examples of similar cases. One patient is independent, has the will to work, and enjoys taking care of himself; the other wants something for nothing.

We have physicians of both types, too. Some accept all the benefits that county, state, and national medical society memberships offer but complain of the dues. Others appreciate the opportunity to practice in a free economy and work diligently to preserve that opportunity for themselves and future citizens. What kind of a physician are you? Do you pull your share of the load?

L. O. Gimenstad M.D.

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Professional Integrity and Responsibility

A Faculty Editorial*

In recent years the charge has been made, with increasing frequency, that our young professional people do not have an adequate sense of responsibility and integrity. Those responsible for education in the professions have shown their concern by discussing it at local and national meetings. The reason offered most frequently for this lack of responsibility and integrity is the gradual decline in liberal education for professional students. In turn the emphasis on courses directly related to the profession in pre-professional training has caused the decline in liberal education. This is particularly true in pre-medical and pre-dental programs in which there has been much emphasis on the sciences.

From all sides we hear the cry, "more liberal education for professional students." The pendulum has even swung so far that some are almost denouncing the sciences as part of pre-medical or pre-dental education. Wiser educators point out, however, that a good general background in the natural sciences is part of a good liberal education for any person. There seems to be no doubt that good exposure to the humanities and the social sciences contributes much to the development of good professional people. It is also true that the humanities have been neglected in recent years in pre-professional training.

It might be well to pause and inquire, how does one acquire a liberal education? Further, does a liberal education automatically give one an adequate sense of responsibility and integrity as a professional man or woman? Probably the two go hand in hand to a considerable extent. But knowledge alone of literature, history, philosophy, and the social sciences does not necessarily cause one to behave with responsibility and integrity. Such knowledge certainly should enable one to distinguish between right and wrong. However, in addition to a liberal education professional people must have a strong sense of social responsibility and must act with integrity toward the individuals with whom they deal.

Liberal education and social consciousness and responsibility begin in the home. Individuals cannot acquire a liberal education without pursuing the intellectual life, at least to some extent. If parents are not interested in leading an intellectual life, it is hardly likely that intellectual curiosity will be aroused in the child. Simultaneously the child must be taught the distinction between right and wrong,

*Reprinted from the *Marquette Medical Review*.

largely through precept and example by its elders. This must be continued through school, college, and professional training. Personal communication between teacher and student is the most effective way of continuing the training begun in the home. Unfortunately, mass production in higher education has largely destroyed the opportunity for personal communication between teacher and student. This can be enjoyed only in the small liberal arts college.

More liberal education for students in the professions will certainly help to develop better professional people. But the mere exposure to courses in the social sciences, ethics, and the like, is not enough. Predicted future enrollments indicate that there will be no escape from large classes. Nevertheless, some means of communication must be devised by which the teacher can exert greater influence on the student.

Our objective may be stated in a few words. We must develop in all students an *adequate appreciation of the individual dignity of man.* This can be accomplished only by continuous influence beginning in the home and maintained through primary and secondary and higher education. Particularly, the teachers training people for the professions must recognize this as one of their primary obligations. Only by such continuous efforts can we restore the dignity and respect which the professions rightly deserve.—Walter Zeit, Ph.D.

Applied Integrity

The medical profession is called upon oftentimes to perform tasks for which seemingly very little appreciation is received. At times these tasks may appear to be coming with undue frequency; but we as physicians, when called upon, must never do anything other than that which displays the best of our ability. Integrity in the practice of medicine is one of the most substantial building blocks in our professional foundation, and we should never allow it to become cracked or destroyed in any way.

At the beginning of each school year, physicians are called upon to provide a variety of physical examinations and health checkups. Some of these are requested on the pretext and with the intent that the student can be excused from participation in physical education courses. The physician very seldom knows the real reason for the request of such a report. A study of abuses along these lines has come up, revealing the following reasons for students wishing to omit physical education courses from their schedules:

1. Afraid of getting the hair wet.
2. To use that hour for study, thereby eliminating homework.
3. Just plain laziness.
4. To be able to sleep later in the morning.

None of these are valid excuses.

The school authorities have cooperated with medicine very well, and medicine should cooperate with them. How best to do this? The next few weeks when students present themselves in the offices of physicians, they should be given very definite and thorough physical examinations. If pathology is found, an excuse from physical education should be given to the student. Such examinations and reports should definitely be on a fee basis.

Physical examinations for athletics are also coming up to face the physician as school begins. Such examinations should be thorough and should also be provided on a fee basis. In this case, the physician's responsibility is actually twofold. He must protect the youth of Wisconsin who should not, for legitimate health reasons, participate in athletics; and he should also remember that this type of program is actually an insurance examination.

Medicine in Wisconsin can set an example for the country by being very thorough and highly conscientious.—James P. Conway, M.D.

RESERVATION BLANK—CIRCUIT TEACHING PROGRAMS

Mark clearly the meetings you will attend . . . make out a check ($6.00 per clinic) to the State Medical Society of Wisconsin . . . mail to State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

I will attend the following teaching programs:

Sept. 11: La Crosse _____
Sept. 12: Eau Claire _____
Sept. 13: Superior _____

Oct. 9: Green Bay _____
Oct. 10: Menominee, Mich. _____
Oct. 11: Wausau _____

Nov. 27: Lancaster _____
Nov. 28: Janesville _____
Nov. 29: Appleton _____

Jan. 15: Madison _____
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Circuit Teaching Programs—1956-1957

The Council on Scientific Work is pleased to announce the following schedule of circuit teaching programs in cooperation with the University of Wisconsin Medical School, Marquette University School of Medicine, State Board of Health, Wisconsin Academy of General Practice, Wisconsin Heart Association, Wisconsin Division of the American Cancer Society, and the Wisconsin Anti-Tuberculosis Association:

(Use blank at bottom of opposite page to make reservations)

Tuesday, September 11—La Crosse ---------- St. Francis Hospital
Wednesday, September 12—Eau Claire ---------- Sacred Heart Hospital
Thursday, September 13—Superior ---------- St. Mary's Hospital

Moderator: **George E. Collentine, Jr., M. D.**, Milwaukee

Faculty and Subjects to be Covered:

John Z. Bowers, M. D., Madison: *arthritis*
George Barnes, M. D., Iowa City: *pediatrics*
James Conley, M. D., Milwaukee: *surgery*
Donald Ruch, M. D., Milwaukee: *dermatology*

Tuesday, October 9—Green Bay ---------- Bellin Hospital
Wednesday, October 10—Menominee, Michigan ---------- St. Joseph's Hospital
Thursday, October 11—Wausau ---------- St. Mary's Hospital

Moderator: **Robert C. Parkin, M. D.**, Madison

Faculty and Subjects to be Covered:

George S. Kilkenny, M. D., Milwaukee: *obstetrics*
Gordon Marlow, M. D., Madison: *Hemorrhoids, Fissures and Premalignant Conditions of the Bowel*
Lamont Schweiger, M. D., Milwaukee: *Cardiac Decompensation*
Martin Seifert, M. D., Chicago: *Use and Abuse of Antibiotics and Chemotherapeutic Remedies*

Tuesday, November 27—Lancaster ---------- Memorial Hospital
Wednesday, November 28—Janesville ---------- Mercy Hospital
Thursday, November 29—Appleton ---------- St. Elizabeth Hospital

Moderator: **George E. Collentine, Jr., M. D.**, Milwaukee

Faculty and Subjects to be Covered:

M. Edward Davis, M. D., Chicago: *obstetrics*
Thomas Geppert, M. D., Madison: *Prematurity: A Common Problem in General Practice*
Sture Johnson, M. D., Madison: *Benign and Malignant Lesions Commonly Seen in General Practice*
Wilson Weisel, M. D., Milwaukee: *Chest Trauma*

Tuesday, January 15—Madison ---------- St. Mary's Hospital
Wednesday, January 16—Oshkosh ---------- Mercy Hospital
Thursday, January 17—Sheboygan ---------- St. Nicholas Hospital

Moderator: **Robert C. Parkin, M. D.**, Madison

Faculty and Subjects to be Covered:

John Hirschboeck, M. D., Milwaukee: *Hematologic Problems in Children*
Howard Lee, M. D., Milwaukee: *Bronchial Asthma, and What Can We Do About It*
Ralph Reis, M. D., Chicago: *Indications and Avenue of Approach for Hysterectomy*
James Stack, M. D., Chicago: *Low Back Pain*

TABLE OF CONTENTS

Transactions of the 1956 Regular Session, House of Delegates, State Medical Society of Wisconsin

Page

First Session, Tuesday, May 1, 1956 ---- 843
Report of Committee on Credentials ---- 843
Excerpts from Address of Speaker ---- 843
Announcement of Reference Committee Appointments ---- 843
Minutes of 1955 Session Approved ---- 844
Standing Rules Adopted ---- 844
Reports of Officers ---- 844
1955 in Review—A Report of the Council 844
Report on Necrology ---- 846
Supplementary Report of the Council ---- 846
Reports of Council Committees ---- 848
Committee on Civil Defense ---- 848
Committee on Military Medical Service 849
Commission on Prepaid Plans ---- 850
Commission on State Departments ---- 858
Division on Maternal and Child Welfare 858
Division on Tuberculosis and Chest Diseases ---- 860
Division on Visual and Hearing Defects 861
Division on Crippled Children ---- 862
Division on School Health ---- 863
Division on Rehabilitation ---- 864
Division on Geriatrics ---- 865
Division on Public Assistance ---- 866
Division on Safe Transportation ---- 867
Division on Nervous and Mental Diseases ---- 867
Wisconsin Veterans Medical Service Agency Operating Committee ---- 868
Excerpts from Report of President ---- 869
Report of President-Elect ---- 872
Report of Treasurer ---- 872
Report of Secretary ---- 874
Supplementary Necrology Report ---- 878
Reports of Standing Committees ---- 878
Committee on Grievances ---- 878
Council on Scientific Work ---- 879
Council on Medical Service ---- 879
Committee on Cancer ---- 880
Committee on Hospital Relations ---- 881
Address of President of Woman's Auxiliary 882
Supplementary Report of Council on Scientific Work ---- 883
Supplementary Report of Division on Maternal and Child Welfare ---- 884
Report of Charitable, Educational, and Scientific Foundation Incorporated ---- 885
Report of State Advisory Committee on Poliomyelitis Vaccine by Doctor Salk 886
Remarks of State Health Officer ---- 890
Remarks of Secretary of State Board of Medical Examiners ---- 892
Remarks of Dean of University of Wisconsin Medical School ---- 893

Page

District X Blue Shield ---- 894
Resolution from Columbia–Marquette–Adams County Medical Society ---- 894
Reference of Reports ---- 894
Certification of Councilor ---- 895
Committee on Nominations Selected ---- 895
Resolution from Manitowoc County Medical Society ---- 895
Adjournment ---- 895

Second Session, Wednesday, May 2, 1956 ---- 895
Report of Committee on Credentials ---- 895
Introduction of Guests ---- 895
Remarks of Dean of Marquette University School of Medicine ---- 896
Report of Reference Committee on Reports of Officers ---- 896
Report of President ---- 896
Report of President-Elect ---- 897
Report of Treasurer ---- 897
Report of Secretary ---- 897
Reports of AMA Delegates ---- 897
Report of State Health Officer ---- 898
Reports of Deans of Medical Schools ---- 898
Report of President of Woman's Auxiliary 898
Report of Reference Committee on Standing Committees ---- 898
Committee on Civil Defense ---- 898
Committee on Military Medical Service -- 898
Veterans Medical Service Agency Operating Committee ---- 898
Committee on Cancer ---- 899
Committee on Grievances ---- 899
Committee on Hospital Relations ---- 899
Council on Medical Service ---- 899
Council on Scientific Work ---- 899
Report of Reference Committee on Resolutions and Amendments ---- 899
Report of the Council ---- 899
Commission on Prepaid Plans ---- 900
Commission on State Departments ---- 900
Poliomyelitis Advisory Committee ---- 901
Charitable, Educational, and Scientific Foundation Incorporated ---- 902
Medical Students in Society Employ ---- 902
Adjournment ---- 902

Third Session, Thursday, May 3, 1956 ---- 902
Report of Committee on Credentials ---- 902
Report of Committee on Nominations ---- 902
Election of Councilors ---- 903
Acceptance by President-Elect ---- 903
Doctor Wilson Introduced ---- 903
Adjournment *Sine Die* ---- 903

Transactions of the 1956 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Tuesday, May 1, 1956

The opening session of the House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, Wisconsin, convened at 6:40 p.m., Dr. J. W. Fons, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials was composed of Drs. H. J. Kief, Fond du Lac, chairman; P. H. Gutzler, River Falls; and M. V. Overman, Neillsville.

The committee verified the registration of 69 delegates and 8 alternate delegates entitled to vote at the first session of the House of Delegates. In addition, 16 alternate delegates, 5 councilors, and 4 officers registered their attendance.

On motion of Doctor Kief, seconded by Dr. T. W. Tormey, Jr., Madison, carried, the attendance roll totaling 77 was accepted as the official roll of this session of the House, to stand for the entire session.

Excerpts from Address of the Speaker

Speaker J. W. Fons: During the time which the House of Delegates is in session you, the delegates, are the ruling body of the State Medical Society. The decisions you make here serve as a mandate to the Council, which acts for you during the interval between meetings of the House.

You are a democratic body, and each and every duly qualified delegate has the privilege of the floor. It is your solemn duty and obligation to your fellow physicians, who sent you here as their representatives, to speak on any question before the House which may be in controversy, so that you may return to your constituent societies with a clear conscience and a feeling that you have justified the confidence reposed in you by them through their selection of you as a delegate.

Robert's Rules of Order are the rules of the House except when the Constitution and By-Laws specifically direct otherwise. The ordinary rules of order may be suspended by a two-thirds vote of the House, but any rule specified by the Constitution or By-Laws cannot be changed except that by-laws may be suspended, according to Robert's Rules of Order, "where they are in the nature of rules of order." The order of business may be changed by majority vote.

The chair would refresh your memory that the House is made up of voting and nonvoting members. The voting members comprise the various delegates, district and section, and those alternate delegates serving in place of their respective delegates. The general officers of the Society and the past presidents of the Society are nonvoting members of the House.

By invitation, the State Health Officer, the Secretary of the Board of Medical Examiners, the delegates to the Student AMA, and other special guests also have the privilege of the floor, but without the right to vote.

The By-Laws require all elections to be by ballot except when there is only one nominee for an office. In that case a majority vote without ballot elects.

The reference committees are a most important part of the House procedure. The members of each committee are chosen by the Speaker with great care, and each committee member is expected to give his best efforts to seek the best answer to each problem and to stand by his honest convictions.

Prior to this first session, your Speaker and several officers of the House had a "briefing session" with new members of the House. We reviewed its procedure, and how important it is to present views before the reference committees, where most of the actual study is done. May I re-emphasize the same point at this time for the benefit of all members of the House.

The reports of the standing committees have been published in the *Annual Report for Delegates* and will be referred to the appropriate reference committees.

I pointed out earlier that you represent your county medical society. In that capacity, it will be expected that you will report to it at an early date relative to actions here. The taproot of our organization is the county medical society. In all appropriate ways you are charged with discussing your actions here with it. To aid you, the staff will send a summarized report within the next 10 days or so. Your Annual Report has been devised this year to provide you with an area for note taking of your own.

Your Speaker intends to observe parliamentary protocol as outlined in the various Rules of Procedure, will recognize all who have the privilege of the floor, and trusts you will not consider him dictatorial if he must call you to order.

Changes in procedure, within the prescribed limits, will be made if the need arises. However, the maxim of St. Paul is still a good one to follow: "Prove all things; hold fast to that which is good."

Announcement of Reference Committee Appointments

Speaker Fons announced the following appointments to reference committees:

Reference Committee on Reports of Officers: Drs. S. A. Morton, Milwaukee, chairman; E. W. Humke, Chilton; F. A. Gruesen, Fort Atkinson; J. H. Houghton, Wisconsin Dells; and C. E. Koepp, Marinette.

Reference Committee on Reports of Standing Committees: Drs. G. W. Carlson, Appleton, chairman; G. C. Hank, Madison; A. J. Baumann, Milwaukee; D. N. Goldstein, Kenosha; and R. S. Hirsch, Viroqua.

Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Drs. T. W. Tormey, Jr., Madison, chairman; Donald Willson, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; and E. D. Sorenson, Elkhorn.

Minutes of 1955 Session Approved

On motion of Dr. E. D. Sorenson, Elkhorn, seconded by Dr. C. J. Picard, Superior, carried, minutes of the 1955 regular session of the House of Delegates, as printed in the September, 1955, issue of *The Wisconsin Medical Journal*, were approved.

Standing Rules Adopted

On motion of Dr. H. J. Lee, Milwaukee, seconded by Dr. G. E. Collentine, Jr., Milwaukee, carried, the following standing rules were adopted for this session of the House:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.
6. Delegates and alternates will sign registration slips at the time they are admitted to each session of the House. Their names will be checked against a list of authorized delegates and alternates previously submitted by the county societies to the state headquarters. If an uncertified delegate wishes to be admitted, he will be referred to the Credentials Committee for its recommendation as to whether he should be admitted.
7. The registration of those in attendance at the House of Delegates, other than as voting delegates, should be handled at a separate registration table.
8. The Credentials Committee should be seated at the registration table to handle any problem that may arise, and in particular the matter of seating an alternate at a session when the delegate himself cannot be present.

Reports of Officers

The following report of the Council was printed in the *Annual Report for Delegates:*

1955 IN REVIEW
A REPORT OF THE COUNCIL

R. G. Arveson, M.D., Chairman.

"Council . . . a body of men elected or appointed to constitute a more or less permanent advisory or legislative body."—*Webster.*

"The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws."—*Art. VI of Constitution, State Medical Society.*

★ **Since May, 1955,** the Council has held sessions in July, October, and February. It will meet prior to sessions of the House in May, and plans a special meeting in late June to discuss current economic matters.

★ **Salk Vaccine** against poliomyelitis has been a subject of special concern. Delegates will recall that a special committee advisory to the Society was organized in the spring of 1955. This committee is now the official advisory committee to the State Board of Health and is under the chairmanship of William B. Hildebrand, M.D., Menasha.

Efforts to clarify information distributed to physicians and to the public have been undertaken as a result of a special mail ballot of the Council in March, acting upon recommendation of the advisory committee.

★ **State activities** bearing upon the field of health are coordinated under the Commission on State Departments, a Council committee which is separately reporting to the House. The Council met in joint session with the Commission for the purpose of aiding in its report appearing in this Handbook.

★ **Ethical principles** have been considered by the Council. In June, 1955, as the result of action in Wisconsin by the House of Delegates, Section 8 of the Principles of Medical Ethics was revised to state a principle rather than vague and uncertain examples.

In December, 1955, the Board of Trustees of the AMA appointed a committee of its members to meet with representatives of two national pharmaceutical organizations. The Council authorized the secretary to transmit to that committee a summary of the Wisconsin situation existing in recent years and to request that, if the "AMA through this special committee is inclined to offer specific recommendations relative to the Principles of Medical Ethics, we submit that medical societies, constituents of the AMA, have a right to be heard upon specific suggestions before a committee report is made." This letter, addressed to the secretary and general manager of the AMA, was accompanied with documentary material relative to the local situation.

In addition, the Council at its February, 1956, meeting had as guests representatives of the Wisconsin chapter of the American Academy of General Practice and of the Wisconsin Surgical Society. A portion of the meeting was devoted to the problems raised where more than one physician assists in the surgical and medical care of patients. The end result of the discussion was the appointment of a special committee composed of Drs. E. L. Bernhart, Milwaukee, chairman, representing the Academy of General Practice; J. M. Sullivan, Milwaukee, representing the Surgical Society; and G. W. Carlson, Appleton, to serve as a representative of the councilors and officers. It is hoped that this particular committee, as a result of its deliberations, will find a mechanism so that statements upon these problems may be authoritatively issued through the State Medical Society as representative of the entire profession in the state.

★ **Scientific medicine** in Wisconsin was the purpose of a meeting of the Council with the Council on Scientific Work in July, 1955. Many of the deliberations of the joint meeting are reflected in the 1956 Annual Meeting program. Special guests of the general Council included Drs. J. S. Hirschboeck, dean of the Marquette University School of Medicine, and John Z. Bowers, recently appointed dean of the University of Wisconsin Medical School.

The general Council points out that a much more effective publicity program has been provided in 1956 and that the cooperative attitude of the organized specialty societies has resulted in a new format which it is believed will be more attractive than the routine followed in prior years. A round-table luncheon has been planned for new members of the Society. During the year, attention has been given to the circuit teaching programs, councilor district meetings, and postgraduate programs in the field of medical-dental responsibility in the early detection of cancer.

★ **Anti-fluoridation** campaigns and the support given to those campaigns apparently stemming from individuals participating in or adhering to cult practices were also discussed by the Council. Some of these campaigns have been nothing short of tragic in their ultimate outcome, and the material laid before the general public has been misguiding in its intent and misleading in its effect. The Council has authorized a special study of this particular matter and hopes that in 1957 documentation and recommendations can be given to the House of Delegates.

★ **Antiquated, vague,** and uncertain public health laws of this state are becoming an increasing cause of concern. In the many years in which they have rested upon our statute books, various court interpretations and opinions of the attorney general have led to a construction which, in some cases, seems to be at variance with a statute itself as it is specifically worded; and thus, consulting the laws does not alone provide the answer. Legislation has been passed at various sessions and, while involving related subjects or similar procedures, has not been integrated as well as it might have been. Consequently, the State Medical Society and the State Board of Health have initiated a joint study relative to the structure of the State Health Department and various laws with which all physicians are concerned in the public health field. While it must be anticipated that the study cannot be concluded within the matter of a year or two, nevertheless, it is hoped that considerable progress may have been achieved in sufficient time to offer specific legislation in the 1957 session.

★ **Interprofessional** meetings at the county level have been urged by the Wisconsin Bar Association and the State Medical Society of Wisconsin in resolutions adopted by their respective councils. The series of proposed meetings has already been initiated successfully in several areas and illustrates the foresightedness which led to the development of the Inter-Professional Code, a publication having had approval of the Council and House of Delegates and one which has received nationwide attention for its detailed observations. At the present time, further joint projects are in study including the possibility of developing some form of mutual understanding as to the availability of hospital records and to more clearly specify the field of privilege in which

patient consent is clearly necessitated. The Council is happy to report that the two professional groups are working well and seriously upon these involved subjects. Their activities deserve the commendation of both professional organizations.

★ **Officers and appointments** made at the Annual Meeting of the Council include re-election of Drs. R. G. Arveson, Frederic, as chairman; F. L. Weston, Madison, treasurer; H. Kent Tenney, Madison, assistant treasurer; and N. A. Hill, Madison, assistant treasurer. Mr. C. H. Crownhart was re-elected secretary; and Drs. R. S. Baldwin, Marshfield, and J. M. Sullivan, Milwaukee, were re-elected medical editor and editorial director of the *Wisconsin Medical Journal.*

★ **The veteran** and his Home Town Medical Care Program have been the subject of much discussion as the result of a letter from W. S. Middleton, M.D., chief medical director of the Veterans Administration, who stated to the Home Town Care Program in Wisconsin, and to others in similar operation, his recommendation that the government terminate existing contracts no later than July 1, 1957. As of the date of writing this report, no formal action has been taken on Doctor Middleton's letter.

The type of home town care program in Wisconsin, which followed the development in Michigan and other states, was intended to be one of primary assistance to the veteran who would be able to obtain ambulatory medical care without the necessity of reporting to VA operated clinics or VA institutions which may not be readily available to him. The program has operated successfully and at a minimum of administrative expense. Further consideration to Doctor Middleton's communication will be given during the course of 1956.

★ **Financial affairs** of the State Medical Society have been consolidated into one operating budget. This was accomplished through the efforts of the Executive Committee of the Commission on Prepaid Plans and the Audit and Budget Committee of the Council, which met in joint session to review 1956 operations and to establish a budget for those operations. It should interest members of the Society that total administrative expenses of all activities operated by the State Medical Society of Wisconsin, including Blue Shield of Wisconsin, now approach $1,000,000 annually. Copies of the budget will be submitted to the Reference Committee on Resolutions.

This has been a summary of major developments and problems during the past year which have been a direct responsibility of your Council and possibly not reported elsewhere in committee activity. Doubtless, there will be a number of other matters which will come before the Council at its session just prior to the Annual Meeting and which will be reported to the House of Delegates via special reports.

Report on Necrology

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by boldface type.

R. L. Bower, Carmel, California
R. R. Jacks, Menard, Illinois
P. F. Dockry, Green Bay
K. J. Klocker, Burlington
G. V. Lynch, Oshkosh
P. H. Perlson, Milwaukee
F. S. Maloney, Madison
L. G. Sykes, Bronxville, New York
H. E. Breckenridge, Green Bay
F. A. Soles, Platteville
D. H. Lando, Sr., Milwaukee
A. D. Andrus, Ashland
J. V. May, Marinette
W. J. Murphy, Milwaukee
J. W. Smith, Milwaukee
T. H. Lorenz, Madison
E. B. Gute, Milwaukee
C. P. Arnoldussen, Fremont
C. F. Siefert, Milwaukee
Felix Schmit, Milwaukee
W. A. Ford, Houston, Texas
S. J. Driessel, West Bend
Edwin Hines, Jr., Milwaukee
D. M. Gallaher, Appleton
W. P. Tippet, Green Bay
C. S. Hayman, Boscobel
D. H. Jeffers, Lake Geneva
E. T. Ridgeway, Lebanon, Illinois
George Crosley, Milton
Joseph Lettenberger, Milwaukee
A. C. Kissling, Sr., Milwaukee
R. S. Ingersoll, Adams
J. E. Schein, Oshkosh
P. S. DesBois, Fond du Lac
J. A. Froelich, Milwaukee
C. D. Partridge, Cudahy
E. M. Jordan, Green Bay
W. W. Witcpalek, Kewaunee
J. J. Minahan, Chilton
A. R. Kaufman, New Kingston, Pennsylvania
J. E. Bryant, Kenosha
H. C. Schumm, Milwaukee
O. G. Ingersoll, Adams
A. L. Tatum, Madison
C. C. Stein, Port Washington
C. G. Richards, Kenosha
W. F. Weingart, Milwaukee
T. J. Budnick, East Troy
C. A. Squire, Sheboygan
V. A. Gudex, Milwaukee
J. H. Carroll, Burlington
P. L. Scanlan, Prairie du Chien

Supplementary Report of the Council

In the absence of Dr. R. G. Arveson, Frederic, Secretary Crownhart read the supplementary report of the chairman of the Council:

The Executive Committee of the Council met Saturday, April 28, and the general Council held its session on Sunday, April 29. It reports to the House:

1. At the suggestion of the Commission on State Departments, it has created a Committee on Diabetes to advise with interested lay groups and to analyze the problem in its medical aspects.

2. It reviewed proposed changes in the Principles of Medical Ethics, to be presented to the American Medical Association at its June, 1956, meeting in Chicago. It is not the policy of the State Medical Society of Wisconsin to instruct its delegates to that meeting, but the Council did suggest careful scrutiny of several of the changes.

It commends the AMA for its own suggestion that in the future changes in the Principles not be acted upon until the session following that in which introduced. The Council suggested that such proposed changes also be a matter of special notice to AMA delegates and officers of the state medical societies.

3. It announces that T. W. Tormey, Jr., M.D., Madison, has been re-elected general chairman of the Commission on State Departments, and that the following were either elected or re-elected chairmen of its various divisions:

H. A. Anderson, M.D., Stevens Point, Chairman of the Division on Tuberculosis and Chest Diseases.

G. S. Kilkenny, M.D., Milwaukee, Chairman of the Division on Maternal and Child Welfare.

Maxine Bennett, M.D., Madison, Chairman of the Division on Visual and Hearing Defects.

H. A. Sincock, M.D., Superior, Chairman of the Division on Crippled Children.

E. H. Pawsat, M.D., Fond du Lac, Chairman of the Division on School Health.

R. W. Boyle, M.D., Milwaukee, Chairman of the Division on Rehabilitation.

A. M. Hutter, M.D., Fond du Lac, Chairman of the Division on Geriatrics.

H. W. Carey, M.D., Lancaster, Chairman of the Division on Public Assistance.

E. D. Schwade, M.D., Milwaukee, Chairman of the Division on Nervous and Mental Diseases.

R. S. Gearhart, M.D., Madison, Chairman of the Division on Safe Transportation.

4. The Executive Committee of the Council is composed of three elected Councilors and several others in ex officio capacity. R. E. Galasinski, M.D., Milwaukee, is now an elected member, his term expiring in 1957. E. L. Bernhart, M.D., Milwaukee, was elected for a term expiring in 1958; and John M. Bell, M.D., Marinette, was re-elected for a term expiring in 1959.

5. For years one of the Society's major projects has been the periodic preparation and distribution of panels of physicians available to treat compensable injuries under the Workmen's Compensation Act. Under its agreement with insurance carriers, the parties have established a mediation committee, which adjudicates problems arising between insurance carrier and physician.

The Council has been informed that osteopaths in this state desire to participate. The Council has directed the secretary to advise this group that the plan cannot be extended to individuals not members of its organization, since it has no authority over and cannot make commitments on behalf of nonmembers. Furthermore, the Open Panel Program was initiated to provide injured employees with free choice of their medical attendant. The project has been one carried entirely at the expense of the Society, and supported by it as a program of much value to the public.

6. The Council's attention has been directed to a law enacted in 1955 which prohibits a funeral director, also serving as coroner, from burying any body he is required to investigate. There are approximately thirty-four funeral director-coroners in the state, and many of these have determined to withdraw from the coroner position. The Council has authorized publicity to the situation, with the thought that in many areas physicians may be available for these positions.

In addition, the Council submits two special matters to the House for its consideration, as follows:

7. Certification of clinical psychologists presented the Council with a difficult subject because of its ramifications and implications. The subject was presented by Dr. E. D. Schwade, Chairman of the Division on Nervous and Mental Diseases of the Commission on State Departments.

It seems that there are about 3,600 clinical psychologists in the United States, of which about 100 are located in Wisconsin. Their services are utilized "in the diagnosis and treatment of individuals with emotional and mental problems or illness." The clinical psychologist endeavors to "help the maladjusted learn new and better habits of behavior."

Another 2,200 are classified as counseling psychologists, in the sense that they confine their activities to assisting individuals in average, everyday problems, that they may sensibly deal with their own problems and decisions.

It is obvious that psychological diagnosis and treatment have a direct impact on the field of medical care because, before and while a problem is treated psychologically, there must be assurance that there is not a medical problem which creates the mental problem.

Psychologists, particularly the clinical psychologists, must work in close liaison with the medical profession. The medical profession respects the learning and the dedication of those who have the degree of Doctor of Philosophy in psychology. The fact remains, however, that those who would treat mental diseases are in fact treating the sick, and doctors of philosophy in the field of psychology are not trained in the medical sciences; yet there are those in the clinical psychological field who fail to appreciate that fact and seek independent certification by state law. The Council and others know that a certification law is but the forerunner of a licensing law. There cannot and should not be different standards under which individuals treat mental disorders.

The Council therefore recommends to the House that the State Medical Society oppose certification by state law as unwise at this time, but that it endeavor in all ways possible to encourage the development of voluntary mechanisms of certification through devices of the clinical psychological group. It is believed premature to expect more than that at the present time, particularly with the limited number in the field. The House of Delegates can emphasize that similar mechanisms exist within the medical profession for specialty certification, and these have worked well and in the public interest.

8. Finally, the Council has endorsed with enthusiasm Governor Kohler's Conference on the Aging Population, to be held in Madison on June 6, 7, and 8, 1956, and forwards to the House of Delegates, with recommendation for its approval, the following resolution pertaining to that conference:

"WHEREAS, medical progress and improved nutrition, housing and sanitation have added nearly a quarter of a century to life expectancy during the past half century, and

"WHEREAS, the rapidly growing numbers of older aged citizens in Wisconsin have produced a severe

strain on what have heretofore been considered proper and adequate concepts of employment, retirement, housing, recreation, health care, and family relationships, and

"WHEREAS, the physician, because he is concerned with the total well-being of his patients as part of their physical and mental health, has a deep interest in the medical, social, and economic problems of the aged; now, therefore, be it

"*Resolved*, That the Council request the House of Delegates of the State Medical Society of Wisconsin to express its belief that the Governor's Conference on an Aging Population, called by Governor Kohler for June 6, 7, and 8, 1956, in Madison, is a most timely opportunity for state-wide consideration of the factors which can make aging either a triumph or tragedy for Wisconsin citizens; and be it further

"*Resolved*, That the Council ask the House of Delegates to commend the Division on Geriatrics of the State Medical Society, the Wisconsin Association for Public Health and the Wisconsin Public Health Council, Inc., for their part in encouraging and developing the Governor's Conference; and be it further

"*Resolved*, That the Council request the Division on Geriatrics to hold a three-day session on June 6, 7, and 8 coinciding with the Governor's Conference, for the purpose of participating in, contributing to, and acquiring information from the Conference as a means of implementing its own activities in this field; and be it finally

"*Resolved*, That the Council request the House of Delegates to issue a special call to each county medical society for the designation of at least one physician to attend the Governor's Conference on Thursday, June 7, to participate in an all-day round-table discussion of 'The Role of the County Medical Society in the Care of the Aging,' so that the medical profession might be better able to carry out its responsibilities to patients and the communities of Wisconsin in the area of health and medical care for the aged."

REPORTS OF COUNCIL COMMITTEES

The following reports of Council committees were printed in the *Annual Report for Delegates:*

ARE WE READY FOR DISASTER?

A REPORT OF THE COMMITTEE ON CIVIL DEFENSE

E. P. Ludwig, M.D., Chairman; J. W. Wier, M.D.; E. A. Bachhuber, M.D., S. J. Graiewski, M.D. and D. L. Williams, M.D.

Disaster is no respecter of persons or places. A flood in Lancaster. An explosion in Madison. A flash fire in Wausau. A cyclone in Rice Lake. A train wreck near La Crosse. A half dozen, maybe a hundred, but rarely more than a thousand people are affected. Local officials and the citizenry react quickly. Medical care is prompt and effective.

But what about a REAL disaster—an enemy bombing attack on Wisconsin cities completely devastating Milwaukee, Fond du Lac, Superior or Beloit and spreading dangerous fall-out across the rural countryside? Casualties by the tens of thousands? Local reaction, if possible at all, would be minimal. What then? Is the medical profession ready to cope with a full-scale disaster?

The Committee on Civil Defense has a simple, straightforward answer: No!

The fact is there never can be fully adequate medical preparation for true military disaster. Preparedness implies a state of readiness and peak training that can deal effectively with the worst type of disaster. This would require such burdens upon the taxpayer for supplies, equipment and personnel that the nation might break its own back without ever being called to action.

Somewhere between all-out preparedness and blissful nonchalance is a sound, sensible approach to civil defense which every physician can support. Remember, the Committee warns, it must be an approach which can endure years of inactivity, yet be capable of almost instant application in event of emergency.

Experience should provide some useful information for the future. Nine years ago, the State Medical Society proferred some serious advice to the profession and the public on civil defense. It urged planning for military disaster and stockpiling of basic supplies. For some years, its suggestions went unheeded. Then A-bomb hysteria shook the world and civil defense was a hit tune.

The Committee on Civil Defense, at the request of the State Office of Civil Defense, developed a plan for 100 mobile medical teams, each team with 29 members captained by two physicians. Four attempts have been made to build these teams to full strength. Four times the effort has nearly succeeded—then faltered. Why?

The answer is relatively simple. It is next to impossible to obtain and sustain the interest of 2,700 laymen and 200 physicians in a studious, devoted, time-consuming, extracurricular activity that has no hope of becoming "live" unless there is a shooting war. And, whether or not it is wise, the American people have an abiding faith that peace somehow is here to stay.

Medicine's ability to "deliver the goods" when human need demands has been demonstrated so often as to require no illustration. The Committee believes the state's medical civil defense can be built around these simple facts: The state's medical manpower is relatively static. It is here. It is always fully trained. It is the core of any casualty care program. Physicians, because of their background, are not individuals who panic; and they can take the lead in caring for the sick and injured and in directing sanitary measures. Physicians do not need to know the utmost detail about what must be done in an emergency; if they get too definitive in their planning, time is wasted on situations which may be exactly the opposite in an emergency.

The Committee believes that the mobile medical team plan in Wisconsin is basically sound, but it cannot be built up to readiness tension and held there indefinitely.

The Committee therefore recommends that the State Medical Society's Committee on Civil Defense undertake to develop, in cooperation with State Civil Defense authorities, a plan along the following lines:

1. **The mobile medical team plan be retained in principle. Two physicians be designated as captain and co-captain of each team. These individuals should be given the responsibility by their county medical society of designating a team business manager and maintaining a close liaison with local, county and regional civil defense officials; being fully acquainted with civil defense procedures in event of disaster; and maintaining a special interest in medical aspects of civil defense and casualty care. They would have full knowledge of supplies, transportation and operation of their teams in event they were called to action. Only in event they were called would they recruit the other 27 members of their teams.**
2. **Since in 1955 the legislature approved a new civil defense law making it mandatory for every town, village, city and county to have a civil defense group, physicians should learn the fundamentals of disaster planning and familiarize themselves with the plans of local civil defense directors.**
3. **The assistant co-director of health services in civil defense should continue his excellent work in organizing the medical team skeleton organization and devote increasing attention to informational and educational efforts among the team captains and business managers.**
4. **Priority should be given to the development of an over-all plan for allocation of casualties to hospital beds, establishment and utilization of temporary hospitals, and the coordination of transportation from mobile medical team aid stations to hospitals.**
5. **Supplies for mobile medical teams and hospitals should be maintained at basic minimums. The current recommendation of the Committee to State Civil Defense officials should be adequate for the foreseeable future.**
6. **Intensive efforts should be undertaken to give the general population minimum first aid training. This will provide a reservoir of basically trained personnel to be recruited as needed in emergencies. The Committee believes this essential because it feels that individual effort will be the key to survival in any attack with nuclear weapons or any major natural disaster. The Committee recommends that this training be accomplished as part of regular school studies in physical education or science in all high schools.**
7. **Physicians chosen as team captains should be invited annually to at least one scientific postgraduate session relating to casualty care and atomic medicine; and the same subjects should be presented periodically as scientific papers in the Wisconsin Medical Journal.**
8. **Efforts should be made to obtain and operate, through private or public means, a fully equipped mobile unit on a demonstration basis for the education of mobile team leaders, local civil defense officials and the public.**

The Committee on Civil Defense believes that these recommendations will in the long run produce a more effective civil defense force. The medical profession cannot be kept ready and waiting for disaster while doing its peacetime job, but it can be and is capable of rapid conversion to an emergency role. The result is for all practical purposes the same; and the cost in time, money, and patience is infinitely less.

SUBJECT: ACTIVE DUTY ORDERS

A REPORT OF THE COMMITTEE ON MILITARY MEDICAL SERVICE

F. L. Weston, M.D., Chairman; M. J. Musser, M.D.; J. M. Sullivan, M.D.; M. H. Steen, M.D. and O. G. Moland, M.D.

It is a rare young physician who escapes receipt of the familiar notice from Selective Service that he is classified "I–A." Currently, nearly 200 physicians registered with Wisconsin local boards hold this ticket to active duty in the armed forces.

The impact of military service on the supply of physicians is clear: The gap between matriculation and practice is lengthened by a minimum of fifteen months to two years. Furthermore, under present policies, only a select few (about 300 nationwide) are permitted to continue postgraduate training without interruption until completion of their residencies.

Three important developments have occurred since the Committee last reported to the House of Delegates:

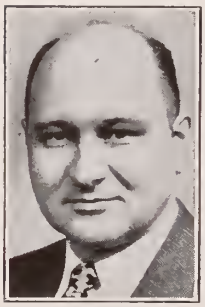
1. **The "doctor draft" law was extended until July 1, 1957. While there are prospects that it might be allowed to die at that time, there are equal possibilities that it will be continued so as to assure the military that virtually *all* newly graduated physicians will be subject to duty. If only the regular draft laws applied, many physicians would be ineligible for service because of family status and age.**
2. **All interns and hospitals were put on notice that physicians accepting residency appointments were doing so at their own risk. Except for the few selected under the residency deferment program, there will be no assurance that a resident will not be called at any time during the year.**
3. **Physicians over 35 whose application for a commission in the armed forces has ever been rejected for physical reasons and all physi-**

cians over 45 were removed from further processing under Selective Service.

The Committee on Military Service continues to provide the Wisconsin Advisory Committee to Selective Service with recommendations on the essentiality or availability of physicians. Since most of the draft calls have been confined to men just completing internships, much of the Committee's work has been routinized.

Nevertheless, the Committee is deeply appreciative of the efforts of the Councilors in providing guidance for the handling of a large number of cases throughout the year. It expresses appreciation, too, for the fine cooperation and assistance of the Wisconsin Selective Service System in dealing with a variety of difficult problems.

A LOOK TO THE FUTURE



COMMISSION ON PREPAID PLANS

E. M. Dessloch, M.D., Chairman; Robert Krohn, M.D., Vice-Chairman; N. A. Hill, M.D., Treasurer; John T. Sprague, M.D., Assistant Treasurer; H. A. Aageson, M.D., G. W. Carlson, M.D., W. T. Casper, M.D., Milton D. Davis, M.D., K. H. Doege, M.D., Milton Finn, M.D., Richard Foregger, M.D., R. E. Garrison, M.D., D. N. Goldstein, M.D., A. W. Hilker, M.D., H. E. Kasten, M.D., P. B. Mason, M.D., R. M. Moore, M.D., C. G. Reznichek, M.D., J. S. Supernaw, M.D., F. H. Wolf, M.D., E. L. Bernhart, M.D., ex officio and L. O. Simenstad, M.D., ex officio.

A group of 22 physicians is responsible, through the Council and the House of Delegates, for the operation of Wisconsin Physicians Service (the Blue Shield plan of the State Medical Society), the Wisconsin Plan, and other insurance activities of the Society.

One of its members, Paul B. Mason, M.D., is a member of the national Commission of Blue Shield Medical Care Plans.

In Wisconsin, the Commission on Prepaid Plans has six working committees.

Executive:

E. M. Dessloch, chairman; Robert Krohn, J. S. Supernaw, H. E. Kasten and E. L. Bernhart.

Claims:

C. G. Reznichek, chairman; N. A. Hill, John T. Sprague and J. S. Supernaw.

Research and Development:

P. B. Mason, chairman; K. H. Doege and H. A. Aageson.

Enrollment and Underwriting:

R. E. Garrison, chairman; R. M. Moore and Richard Foregger.

Physician and Public Relations:

G. W. Carlson, chairman; Milton Finn, W. T. Casper and L. O. Simenstad.

Blue Cross Committee:

E. M. Dessloch, C. G. Reznichek, P. B. Mason, R. E. Garrison and G. W. Carlson.

BLUE SHIELD GROWS . . .

Protection of choice:

- ★ Basic "A" and "B" — Surgical—in-hospital medical—anesthesia—x-ray—maternity
- ★ Major Illness Insurance
- ★ Special service coverage
- ★ $25 deductible coverage
- ★ Extension of in-hospital medical care to 70 and 120 days
- ★ Home and office medical
- ★ First day surgery-medical for the newborn
- ★ Expanded schedules of benefits
- ★ Diagnostic x-ray and laboratory services
- ★ Radiation therapy
- ★ $5,000 specific disease coverage

Five years ago, Wisconsin Physicians Service had little more to offer than a single basic and limited contract available primarily to groups. That contract was expanded in its coverage, broadened in its benefit structure by "A" and "B" fee schedules. Groups and individuals have demanded and received a wide choice of protection. Now groups and individuals have the opportunity to purchase sound basic "A" and "B" programs and can choose from a variety of additional benefits to complement their basic protection.

The Blue Shield plan of the State Medical Society has begun trial sale of a medical-surgical contract based on a concept which is perhaps one of the most significant developments of recent years in the health insurance field. The principal difference between the new Blue Shield contract and conventional insurance contracts is the elimination of benefit schedules. Benefits are provided by paying attending physicians' usual fees for most services covered under the contract.

With the ever-changing economic picture, income limits for full payment with a fixed schedule of benefits present a continuing source of difficulty to the insured patient, the physician, and the insurance carrier. Under the new contract with no income limits and no schedule of benefits, the patient can be assured of full payment of most of his physicians' charges, the physician can feel free to bill his usual charges for services performed considering the medical and economic factors encountered in each case, and Blue Shield can feel that it has taken another major step toward its goal of providing adequate *voluntary* health insurance to the people of Wisconsin in a form which does not interfere with the usual patient–physician relationship. Such a contract—where it is sold—will in a large measure

WISCONSIN PHYSICIANS SERVICE
330 EAST LAKESIDE STREET • MADISON 5 WISCONSIN
THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN
"THE DOCTORS PLAN"

Dear Doctor:

The health insurance programs of the State Medical Society have concluded another successful year of service to the Wisconsin community. Wisconsin Physicians Service has made significant steps in the direction of what might be termed the ultimate in voluntary insurance protection. The Wisconsin Plan, with seven large companies participating, continues to provide a sizable segment of the population with assurance of surgical-medical protection approved by the profession.

In relation to Wisconsin Physicians Service, the importance of the phrase "The Doctors' Plan" is increasingly clear. Every physician rather commonly shares the frustration of patients whose faith and pocketbooks have been shaken by substandard policies which fall far short of providing either adequate fees or coverage. The members of the State Medical Society decided to establish Blue Shield in recognition of the fact that the physician has a very real responsibility to consider cost as part of his concern for the patient's well being. The Commission has attempted, and it believes successfully, to keep Wisconsin Physicians Service at a standard which physicians will be proud to support and recommend.

"The Doctors' Plan" -- established and directed by members of the State Medical Society -- is truly the doctors' program for their own patients. When the patient wants to know what his doctor recommends, is there any better answer than to suggest Blue Shield -- the plan in which the doctor has a voice, in which he is a participant, and in which he has a stake as a professional man and a servant of the public good?

This is not merely a report on past progress but on thinking that will determine the pattern of Society-sponsored health insurance programs for many years ahead. Let this report be a guide for what must be done if tomorrow the people of Wisconsin will regard the State Medical Society as the measuring stick of protection for doctors' care expense

E. M. Dessloch M.D.

E. M. Dessloch, M. D., Chairman
Commission on Prepaid Plans

restore to the physician his autonomy to practice medicine in light of his local needs, an autonomy which over the past several years has been gradually usurped by demands of third-party interests.

The administration of the new contract presents some problems not encountered previously. Each claim must be judged on its own merits since a wide variety of factors enters into the determination of a usual and reasonable charge. It is evident that active cooperation of local physicians is imperative if the new contract is to be successful.

In Polk County, Blue Shield has arranged with a local insurance agent to sell Blue Cross and Blue Shield on a non-group basis. The first year of the experiment appears successful but indicates that rates for health care coverage in the lower income areas of the state must be adjusted while at the same time maintaining a reasonably sound benefit structure.

The Commission has authorized an experiment in local, direct non-group selling through the use of a mobile enrollment unit. A trailer unit may visit more than 100 small towns annually, accompanied by adequate promotion and local physician support.

SALES AND CONSERVATION

All but 25,000 of Blue Shield of Wisconsin's 125,000 contracts are in group-type business. The group market in Wisconsin is virtually saturated—every sizeable group having surgical-medical protection of some kind. Few new groups are available. Carriers merely exchange installations.

Reports indicate that Wisconsin ranks second in the nation in the percentage of total population protected by some type of health insurance. Yet, in an area of the state served by Wisconsin Physicians Service, the most serious problem of both the physician and the patient seems to be substandard coverage in many groups and certainly among persons who pay premiums directly. Too many people have purchased policies in the belief that any health insurance plan is adequate insurance. Blue Shield of Wisconsin contracts represent a standard to which it would be well to educate patients as a major step toward understanding the meaning of good protection.

Wisconsin doctors can be proud of benefits offered by their plan. To assure a steady growth, the Commission believes that consideration should be given to:

1. **Improving the sales force through expansion of personnel and better sales representative selection and salary schedules.**
2. **Gearing sales territories to small group and nongroup contacts.**
3. **Closer coordination of sales and physicians' relations.**
4. **Improved servicing of groups of all sizes.**

Many of the largest groups in Wisconsin have branch or home offices in other states. These plants desire relatively uniform coverage for all their employees no matter where they live or work. Blue Shield finds it difficult to write nationally uniform benefits through 76 independent local plans. Wisconsin Physicians Service proposes its Special Service coverage as a solution to the national enrollment problem, since it frees both physician and patient from the troublesome problems of fee schedules and income levels.

New methods should be considered to economically bring "city-type" benefits to rural and other self-employed persons. The Commission suggests a special study including such proposals as:

1. **Creating groups through checking accounts and allowing non-group subscribers to "bank" their premiums locally.**
2. **Limited period enrollments with less restrictive underwriting.**
3. **Elimination of pre-existing condition clauses after 9-month waiting periods have been served.**
4. **Expansion of number of local non-group sales agents as demonstrated in Polk County.**

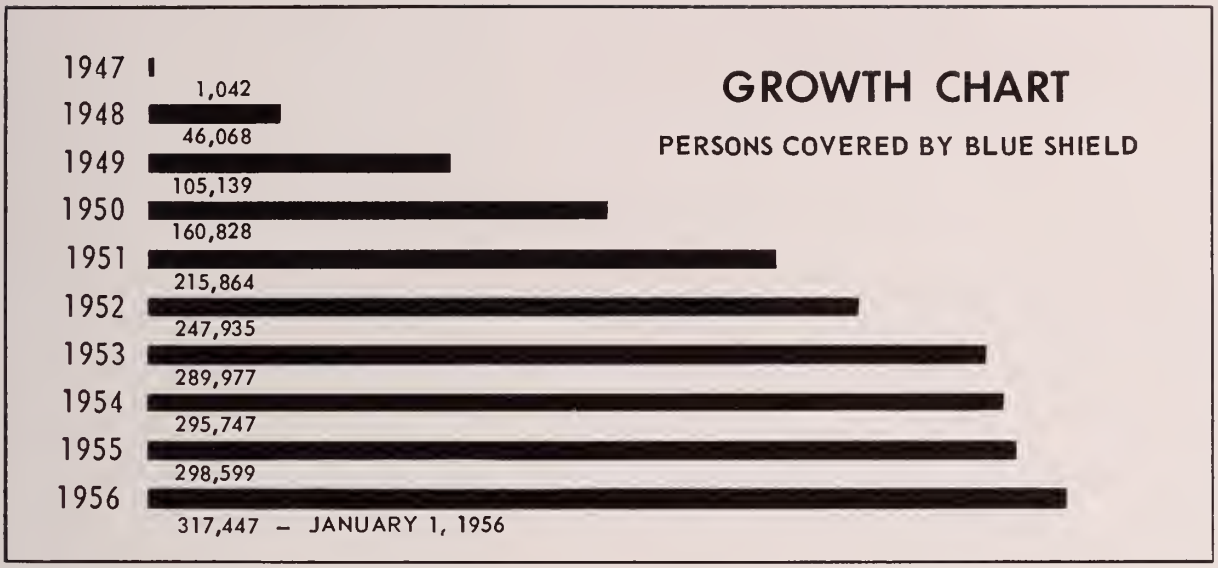
Health expense insurance for older age groups presents two distinct problems: What to do for those now above 65 and ineligible for insurance under usual concepts of underwriting, and how to prevent younger age groups from maturing into the same situation. The aged who are with us now may find some relief if the age limits on enrollment could be raised at least slightly. Some might be aided by a type of "balanced enrollment" in which the enrollment of a specified number of persons under 35 in a given area would make eligible for enrollment a certain number of those over 65. For many in the present old age category, a combination of voluntary and government effort may provide the only solution.

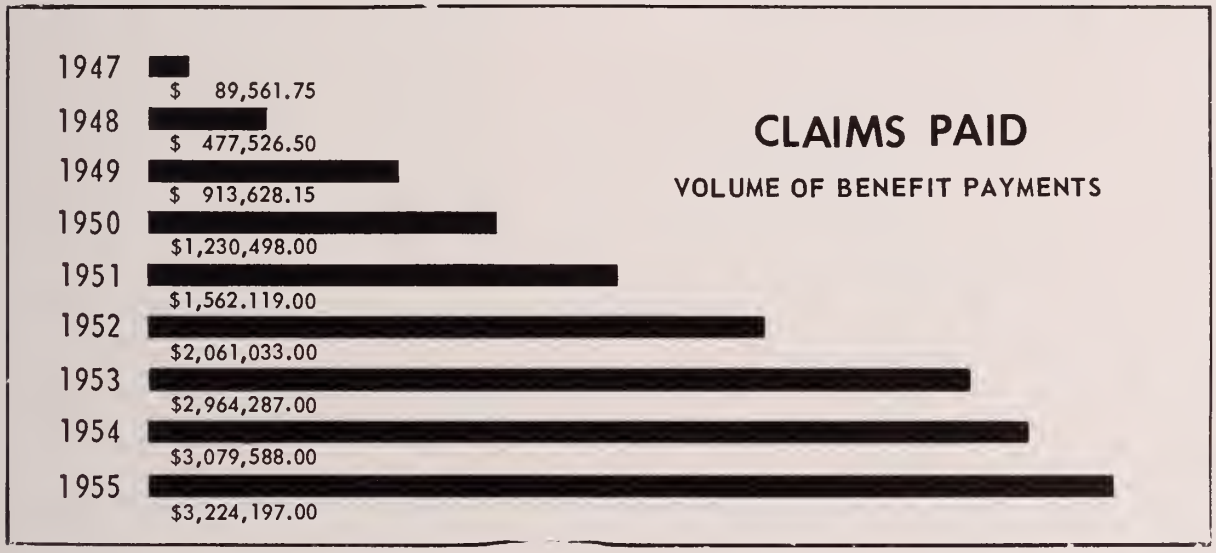
The long-range solution to the problem of insurance protection for the aged lies in developing programs which meet the problem before it arises. The Commission believes immediate thought should be given to the development of policies which allow the subscriber to partly or fully pay up retirement insurance protection during the years of his highest earning capacity. At the same time, Blue Shield's rating systems may be adjusted to permit lower rates for retired persons.

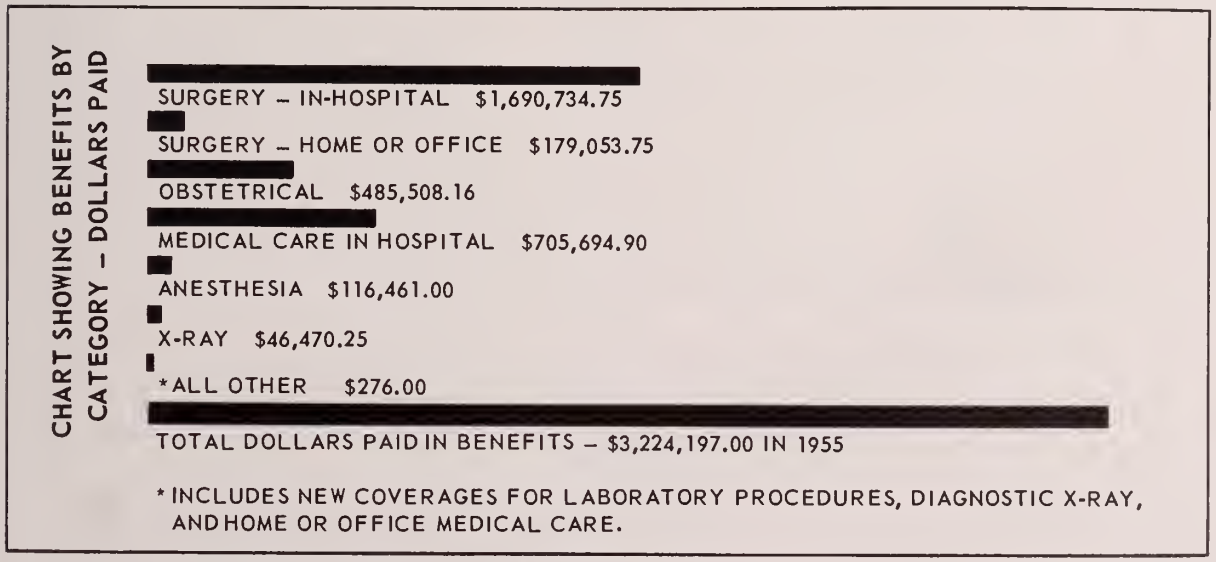
RESEARCH AND UNDERWRITING

The statistical and actuarial sciences are useful only when they point the way for Blue Shield to become a more effective agent of adequate protection. The Commission recommends that the Society's research and underwriting resources be employed in:

1. *Determining a sufficient exposure of the "doctors' usual fees" contract to permit accumulation of sound experience.*







(Continued on page 856)

ACHROMYCIN*

Tetracycline *Lederle*

ACHROMYCIN is unsurpassed in its range of effectiveness. Each successive month more physicians are confirming this fact for themselves in their own daily practice in the therapy of respiratory, genitourinary, dermatologic and other infections.

ACHROMYCIN can be of service to you because of these important advantages:

- true broad-spectrum action
- rapid diffusion and penetration
- prompt control of infection
- proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa
- side effects, if any, usually minimal
- produced under exacting quality control in Lederle's *own* laboratories and offered *only* under the Lederle label
- a *complete line* of dosage forms

ACHROMYCIN SF

ACHROMYCIN Tetracycline with STRESS FORMULA VITAMINS for severe or prolonged illness. Attacks the infection—defends the patient—hastens normal recovery. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Lederle

*REG. U. S. PAT. OFF.

PHOTO DATA: 8 X 10 GROVER VIEW CAMEPA
100 SEC. AT F.22 EXISTING LIGHT

AGRONOMIN

(Continued from page 853)

LEADING EAU CLAIRE COMPANIES CHOOSE BLUE CROSS-BLUE SHIELD

CONSUMERS CO OP ASSOCIATION has shown steady growth since new home was completed just 7 years ago. Now 4,580 members they are in the process of tripling the size of the Co-op Shopping Center.

HUTCHENS INDUSTRIES employs over 35 persons. The Company manufactures over 130 different size cut fittings and distributes them all over the world.

EAU CLAIRE COUNTY EMPLOYEES center their activities in the new Eau Claire County Courthouse Annex. The top floor houses the County new modern sheriff's office and in the four floors and basement are many county departments.

WALTER BREWING COMPANY is one of Eau Claire's oldest businesses. The firm employs about 50 people brews and distributes the well known Walter Beer throughout northwestern Wisconsin.

HOTEL AND MOTEL EAU CLAIRE offer some of the finest accommodations in the Northwest. The Colonial Grill of the Hotel is famous for fine food and is recommended by Duncan Hines. The same management also operates the new, modern Eau Claire Motel, just east of the City.

These leading organizations — and hundreds of others like them in Eau Claire — are Blue Cross and Blue shield groups. They and their employees play an important part in the dynamic growth of Blue Cross and Blue Shield in Eau Claire, in Wisconsin, and throughout the nation. Blue Cross and Blue Shield are the leaders in the field of prepaid health care. We are proud that so many thousands of Eau Claire families have placed their confidence in our programs.

Here are the reasons Blue Cross and Blue Shield are the best protection for you and your family.

BROAD COVERAGE. Blue Cross protects members against a broad range of hospital service. Blue Shield provides benefits for the physicians' services involved in surgery, maternity care, in-hospital medical care, x-ray and anesthesia.

SERVICE BENEFITS. Blue Cross offers a plan paying the full cost of a semi-private room and virtually all hospital care up to 70 days. Blue Shield offers two Plans which provide payment in full or part for families whose income is less than $4,800. For families with higher income Blue Shield provides liberal payment for the doctor's service.

NO CLAIMS TO FILE. Blue Cross and Blue Shield have no complicated procedures which involve no red tape. Neither the individual nor the employer has any forms to prepare.

PROMPT PAYMENT. Blue Cross and Blue Shield in Wisconsin pay members by mail or at a rate of one claim a minute for every working day of the year.

Full-page ads in key population centers attracted wide-spread attention and inquiry.

It is a maxim that the best advertising is the satisfied customer.

Because Blue Shield employs the philosophy of direct payment to participating physicians, it is a strange fact that many Blue Shield subscribers do not know or appreciate the part that Blue Shield has had in the payment of their health care expenses. Throughout 1955, Wisconsin Physicians Service issued notices of payment to 100,000 subscribers indicating that pyament for services was made directly to the physician. In addition to an advertising function, this procedure serves a definite public relations purpose through the detection of erroneous payments.

A State Medical Society field representative spends much of his time visiting physicians, county medical societies meetings, hospital staff meetings and Blue Shield subscribers. Personal contact proves to be the best remedy for misinformation and misunderstanding.

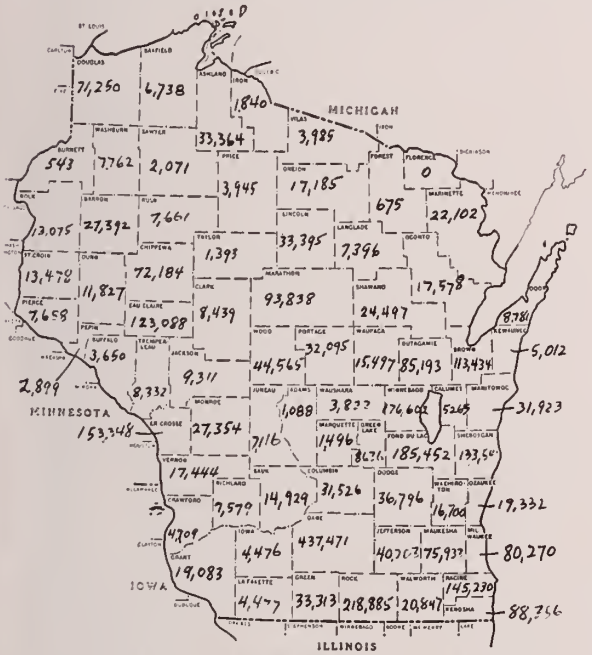
CITY OF EAU CLAIRE EMPLOYEES center their activities around the City Hall which houses most of the city government. The police, fire and health departments are in the new Safety Building on Grand Avenue East.

EAU CLAIRE PRESS CO. publishes the Eau Claire Leader (morning) and The Daily Telegram (evening). The papers circulate in a 50 mile radius. Only two other wisconsin cities have two daily papers.

BLUE CROSS
the Hospitals' Plan

BLUE SHIELD
the Doctors' Plan

2. **Exploring the feasibility of health program analysis for industry as a corollary service of sales and conservation.**
3. *Reviewing the Blue Shield major illness insurance policy with an eye to improving the deductible feature and making the coverage available to small groups and individuals and at lower over-all rates.*
4. **Thorough review of the Society's insurance offerings to assure that they foster the principle that an ideal health insurance program provides for all professional services; and exclusions, if any, should relate to a portion of the charges rather than a modality of service.**
5. *Studies to exhaust all possible means of offering non-group policies without vague, permanent exclusions and undue age restrictions.*
6. **Preparing a special report on the feasibility of rewarding good health with premium credits or extension of coverage upon retirement.**



This chart shows benefit payments by counties in 1955.

CLAIMS HANDLING

Service is an increasingly important element in physician and public acceptance of Wisconsin Physicians Service. The Commission recommends:

1. Investigation of the need for regional service offices of Blue Shield primarily for claims settlement purposes.
2. Development of proposals for closer relationships between the Wisconsin Physicians Service Claims Committee and county society fee committees.
3. Special efforts to integrate nationally standardized claim forms with those currently in use by Wisconsin Physicians Service.
4. Study of means to speed the claims payment process of Wisconsin Physicians Service by more direct routing of Physicians Service Report forms from the doctor to Blue Shield on hospitalized as well as non-hospitalized cases

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin
BALANCE SHEET
December 31, 1955

Assets		
Cash on Hand and in Banks		$ 531,311.23
Due from Agent		218,626.39
Refunds Receivable—Net		795.00
Accounts Receivable		5,878.40
U. S. Government Bonds—Net	$2,025,769.38	
Less: Reserve for Excess of Book Value over Market Value	20,735.00	
	$2,005,034.38	
Accrued Interest Income	1,781.79	2,006,816.17
Mortgage Loan	$ 270,000.00	
Accrued Interest Income	2,177.78	272,177.78
Leasehold Improvements—Net		24,500.00
Office Furniture and Fixtures—Net		22,284.43
Prepaid Reinsurance		1,000.00
Deferred Charges		1,056.16
Total Assets		$3,084,445.56
Liabilities and Reserves		
Accounts Payable		$ 17,661.72
Merit Rating Credits Payable		5,005.44
Physicians Claims Payable		450,400.00
Reserve for Old Outstanding Checks		3,283.00
Unearned Income		391,936.28
Reserves—Maternity Benefits	$ 241,200.00	
Disaster Claims	341,151.00	
Major Illness Expense	100,000.00	
Unforeseen Contingencies	740,865.12	
Administrative	707,524.84	
Investment	85,418.16	2,216,159.12
Total Liabilities and Reserves		$3,084,445.56

COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES
FOR THE PERIODS JANUARY 1 TO DECEMBER 31, 1954 AND 1955

	1-1-55 to 12-31-55	1-1-54 to 12-31-54	Increase or (Decrease)
Income			
Earned Premium Income	$4,434,336.63	$4,309,058.25	$125,278.38
Other Administrative Income	3,428.40		3,428.40
Investment Income	38,520.49	29,242.62	9,277.87
Total Income	$4,476,285.52	$4,338,300.87	$137,984.65
Expenditures			
Benefits Incurred	$3,403,526.92	$3,274,848.33	$128,678.59
Expenses of Agent	324,956.71	305,264.15	19,692.56
Salaries	147,436.59	125,046.93	22,389.66
Legal Expense	10,029.39	11,798.01	(1,768.62)
Auditing Expense	6,906.75	9,257.90	(2,351.15)
Actuarial Expense	7,075.66	12,419.34	(5,343.68)
Conference Expense	12,598.44	14,992.83	(2,394.39)
Staff Travel	8,624.88	7,832.02	792.86
Stationery and Supplies	7,228.23	6,682.55	545.68
I.B.M. Expense	12,649.62	12,361.17	288.45
Rent	20,667.75	11,167.00	9,500.75
Office Expense	3,102.79	3,224.12	(121.33)
Postage and Express	6,158.69	4,453.59	1,705.10
Telephone and Telegraph	3,282.78	3,427.72	(144.94)
Payroll Taxes	3,649.29	3,679.22	(29.93)
Employees' Group Insurance	1,829.13	1,660.21	168.92
Depreciation	3,004.04	2,620.98	383.06
Insurance	1,295.90	667.21	628.69
Association Dues	4,621.15	4,253.42	367.73
Conservation and Promotion	27,223.58	19,357.33	7,866.25
Other Administrative Expenses	10,018.29	6,554.29	3,464.00
Total Expenditures	$4,025,886.58	$3,841,568.32	$184,318.26
Available for Reserves	$ 450,398.94	$ 496,732.55	$(46,333.61)
Distribution of Each $100.00 of Income			
Benefits Incurred	$ 76.03	$ 75.49	$ .54
Expenses of Agent	7.26	7.04	.22
Other Administrative Expenses	6.64	6.03	.61
Additions to Reserves			
Service Benefit Reserves	5.77	6.50	(.73)
Administrative Reserves	3.44	4.27	(.83)
Investment Reserve	.86	.67	.19
	$ 100.00	$ 100.00	$

GOVERNMENT INTEREST IN HEALTH CARE GROWING

A REPORT OF THE COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., M.D., Chairman; H. A. Anderson, M.D.; R. F. Purtell, M.D.; Maxine Bennett, M.D.; R. G. Piaskoski, M.D.; A. M. Hutter, M.D.; E. H. Pawsat, M.D.; H. W. Carey, M.D.; H. A. Sincock, M.D.; E. D. Schwade, M.D. and R. S. Gearhart, M.D.

Public Assistance Costs Rising! Hearing Clinic Held! Vision Test Planned! Governor Calls Meeting on Aged! County Studies TB San Costs! County Okays Mental Unit!

The daily headlines tell the story of the need for the Commission on State Departments. The role of government in health care increases year by year. The responsible agencies of government, in turn, are looking to the medical profession for advice and guidance. Likewise, the State Medical Society attempts to do its utmost to guide governmental health programs into sound, long-term channels.

This report of the divisions of the Commission should be ample evidence of the continuing need for close liaison with all branches of government concerned with health care.

OPERATION "LIFESAVER" AIDS MOTHERS AND BABIES

A REPORT OF THE DIVISION ON MATERNAL AND CHILD WELFARE

Robert F. Purtell, M.D., Chairman; E. A. Birge, M.D.; T. V. Geppert, M.D.; F. G. Johnson, Jr., M.D.; G. S. Kilkenny, M.D.; A. H. Stahmer, M.D.; D. D. Willson, M.D.; J. D. Wilkinson, M.D. and T. A. Leonard, M.D.

"Long distance from Viroqua," the telephone operator said to a Madison obstetrician as she reached him at 2 a.m.

"Go ahead," replied the doctor, a member of the Division.

"This is Doctor ————. I've just delivered a young women. She's hemorrhaging. Hypofibrinogenemia. How can I get some fibrinogen—quick?"

Two hours later, the doctor in Viroqua received the vital substance, and a mother's life was spared. Two years ago, that might not have happened.

Behind this tense little drama is the work of a determined group of obstetricians, pediatricians and general practitioners who make up the Division on Maternal and Child Welfare. Quite unheralded, dozens of similar incidents are taking place throughout the state; and countless others never reach the crisis stage because of increasingly improved prenatal and delivery care.

Hemorrhaging as a result of hypofibrinogenemia can be controlled by the administration of fibrinogen, a blood product. Until late 1953, fibrinogen was available in Wisconsin only at Milwaukee and Madison. Many physicians had but scant knowledge of the condition or how to detect it. If they did, they couldn't get the fibrinogen.

This situation didn't come to light until the Division began its maternal mortality survey in 1953 with the aid of the State Board of Health. A careful study of maternal deaths revealed that hypofibrinogenemia was a factor in several. The Division took its findings straight to the physicians through hospital staff sessions, medical society meetings, and special "OB" refresher courses. In addition, it has prompted storage of fibrinogen for emergency transport to patients anywhere in the state. The end result: Another lifesaving step by the medical profession in its struggle to reduce infant and maternal deaths to the "irreducible."

Happily, Wisconsin has one of the lowest maternal death rates in the country. Any death is tragic, but the death of a mother in childbirth is often calamitous in terms of its impact on the surviving family.

Last year (1955), there were nearly 92,000 births in Wisconsin. There were about 24 true maternal deaths. Many parts of the nation look with envy on such low rates, but the Division on Maternal and Child Welfare believes it has a worth-while mission so long as even a single life might be saved.

Fifteen obstetricians selected by a special study committee have voluntarily given their time for teaching programs at hospitals from Ashland to Burlington and from Richland Center to Menominee, Michigan. In 7 months, they have discussed the significant factors in Wisconsin maternal deaths before the medical staffs of 50 hospitals.

This professional self-examination and education is good for the physicians and better still for their patients. Dr. Robert F. Purtell, chairman of the Division, comments:

"We urge each hospital staff to set aside one meeting per year for a discussion of maternal deaths. Our Division will be happy to supply speakers for this type of staff conference. Only when all of us have an opportunity to study obstetrical hazards which result in demise can we hope to obtain our objectives of an even lower mortality rate than we now experience."

The beneficial effects of the maternal mortality surveys have prompted the Division to still other "lifesaving" programs. They are aimed at further reducing the rate of infant deaths. In 1955, there were 2,200 infant deaths (under 1 year) in over 91,000 live births. During the past two years, 54 physician-nurse teams have attended eight "Prematurity Institutes" arranged by the Division and the State Board of Health. Each institute is a two-day session at which the teams brush up on new techniques for handling the delicate "premies."

The teams return home to put their new knowledge to work in local hospitals.

The results have been immediate and gratifying.

North . . .: "Since a nurse and I attended the institute, our hospital has revised and simplified the tube feeding routines of the prematures, obtained new equipment for tube feeding, and purchased an oxygen analyzer."

East . . .: "Definite strides have been taken to improve the facilities for premature care . . . We have purchased two new Isolettes, an oxygen analyzer and an air compressor for use with mist therapy . . ."

South . . .: "We have appointed a committee to care for prematures and to be on call for any emergencies. The staff and nurses are more cognizant of the problems of these infants."

West . . .: ". . . Changes have been made in physical plant . . . Some outmoded ideas and practices have been discarded . . . I think the greatest advantage has been a reawakening of the problems associated with prematures so that these can be anticipated before something happens."

In addition, the Division bulletins all Wisconsin hospitals and maternity homes whenever new research points out some improved technique to be used in infant care. The latest bulletin, on retrolental fibroplasia, was sent in November, 1955.

One of the most unusual undertakings of the Division and the State Board of Health—the first of its kind in the nation—was accomplished in a month and a day. Between October 31 and December 1, a series of 38 three-hour sessions was held in 24 cities to provide nearly 1,800 police officers with instructions on "the protection of mother and infant in case of emergency delivery."

The program was co-sponsored by the associations of police chiefs and sheriffs and the Milwaukee office of the FBI. Local physicians lead the discussions in each city. Films, manikins, dolls, charts and even fresh pathological specimens were used to lend realism to the instruction. Comments ranged from a mild "very well done" to an enthusiastic "we should have more of this type of training." Even though most of Wisconsin's 5,000 plus premature babies are born in hospitals, emergencies sometimes upset the best of plans. The state's police officers want to be ready.

Fetal-neonatal deaths are also being surveyed by the Division. What started out in 1954 as a pilot study has almost overwhelmed the Division and its staff assistants. Sixteen study teams have reported 1,490 cases under study in 42 hospitals. Lack of uniformity of hospital records resulted in less adequate data than was hoped for. But two facts stand out clearly:

1. The best way to save infants is to reduce premature deaths.
2. The best way to reduce premature deaths is to impress upon every pregnant woman the necessity of early and adequate prenatal care, whether she is having her first, fifth, or twelfth baby, and to provide special attention to mother and child at the time of delivery and during the next 48 hours.

Wrapping and care of newborn babies was demonstrated by Dr. D. L. Williams at a clinic in Madison wherein police officers received instruction on childbirth emergencies. With Dr. Williams (holding doll used in demonstration) above are Tom Muldowney (left) and Bill Hughey, of the Dane County Traffic Department, and Traffic Sgt. Norman Ehle (right), of the Madison police department — (Madison Capital Times photo).

The fetal-neonatal studies will undoubtedly produce many valuable conclusions for physician education; but if they do nothing more, they will be worth their weight for having clearly demonstrated that the job of lay education in prenatal care and infant care needs to be carried much farther.

The Division is planning another promising project designed to further improve hospital records and thus save lives by outguessing trouble. In preparation is a report sheet called "Pertinent Prenatal Facts" which can be sent to the hospital by the attending physician at the beginning of the last trimester of pregnancy. This will forewarn the hospital of the likelihood of any type of abnormal birth, the patient's physical condition, blood compatibility, possible baby-feeding problems, and any "special precautions to be taken in guidance of labor and delivery."

Still not satisfied that its efforts are sufficient, the Division is making the following recommendations for the coming year:

1. Each hospital staff should devote one full staff conference per year for a review of maternal deaths and special hazards of obstetrics.
2. All hospitals which have not yet participated in prematurity institutes are urged to do so during the ensuing year.
3. In the coming months, special attention should be directed to the subject of anesthesia in relation to obstetrics through hospital studies, postgraduate training programs, and papers in the Medical Journal.
4. Each physician is urged to utilize the proposed prenatal fact report to be filed with the hospital prior to delivery so that emergencies can be anticipated through prior knowledge of the patient's condition. It is further recommended that hospital staffs endorse this program and make it an obligation of individual staff members to provide such

information on all obstetrical patients to be admitted.

5. Local studies should be undertaken to review fetal and neonatal deaths through expansion of autopsies with the active participation of pathologists so that greater salvage in this field might be achieved.

Wisconsin is a good place to be born, and there is every likelihood that it will get better . . . thanks to the Division on Maternal and Child Welfare and a most cooperative State Board of Health.

THE FACTS ABOUT TUBERCULOSIS

A REPORT OF THE DIVISION ON TUBERCULOSIS AND CHEST DISEASES

H. A. Anderson, M.D., Chairman; Einar Daniels, M.D.; Helen Dickie, M.D.; D. A. Gutheil, M.D.; F. B. Landis, M.D.; L. W. Moody, M.D.; G. C. Owen, M.D.; A. A. Pleyte, M.D. and C. M. Yoran, M.D.

The captain of the Legions of Death has lost his rank, but the war against tuberculosis is far from won. In Wisconsin, both the public and physicians have been lulled into the belief that tuberculosis is a conquered disease. The facts are these:

- ★ **TB is still a serious menace: It is estimated that at least 25 per cent of the population are reactors.**
- ★ **In 1954, there were 1,300 reported cases of active TB; many more known, but not reported.**
- ★ **TB is on the increase in some areas of the state; in some, there are serious "pools" of infection.**
- ★ **Antibiotics and surgery have greatly reduced the TB death rate, but hospitalization is still necessary during the infectious period.**
- ★ **Wisconsin needs at least three times as many mobile units to do an adequate case-finding job.**
- ★ **Incidence of new TB is ten times greater in mental hospitals than in the general population.**

True, great strides have been made in treatment and control. Wisconsin offers TB treatment second to none. As a result, patients are ambulatory earlier, and TB beds are increasingly empty.

In spite of all this, the Division on Tuberculosis and Chest Diseases reports that the considerable amount of tuberculosis in the state must command the immediate and serious attention of all physicians and public health authorities.

The first step in TB control is case finding. The private physician's alertness in detecting tuberculosis is the key to continued improvement in this field. But the profession needs to be impressed with the prevention of tuberculosis and the need for cooperation with all agencies in special case-finding efforts. Sputum samples should be collected from every patient who coughs or spits. Examinations can be conducted in the physician's office laboratory; or if such facilities are not available, the sputum samples can be examined by private laboratories, the State Laboratory of Hygiene, or the laboratory services of the various county sanatoria.

Physicians are urged to read a forthcoming Wisconsin Medical Journal article by Dr. Helen Dickie which will discuss tuberculin testing programs and their value in a state-wide detection program.

The State of Wisconsin has three mobile units—only about one-third of what it needs to adequately cover the state, even with the units operated by the Wisconsin Anti-Tuberculosis Association. So busy are the units that they can survey the state's mental hospitals only once every two or three years, where they should visit once or twice a year.

Forty hospitals report that they obtain x-rays on anywhere from 15 per cent to 90 per cent of all admissions. The discovery rate is surprising. The Division believes that routine admission x-rays should be established in all hospitals.

Children spend at least half their waking hours in school. Thus, the necessity for regular programs of examination of all school employees is obvious. The Division recommends that 14-inch by 17-inch films be taken by competent radiologists and that interpretation be sent to a designated physician who would be responsible for reporting findings to the local board of education.

TB in mental patients is one of the more serious problems. The 18,000 mental patients in Wisconsin (.5 per cent of the population) harbor 6 per cent of the state's TB cases. Incidence of new cases is 40 per 100,000 state-wide; 470 per 100,000 in the mental hospitals. Twelve per cent of all TB deaths occur in mental hospitals.

While this picture is far better than in some states, the Division is concerned that this readily controllable group appears to be a "pool" of infection from which the mentally rehabilitated are released to go home as seed spreaders of tuberculosis.

Significant progress is being made in this area, however, as a result of the efforts of Dr. Leslie Osborn, director, and Dr. Kathryn Schwerma of the Division of Mental Hygiene of the State Department of Public Welfare. The directors of Muirdale Sanatorium are to be commended also for establishing special facilities for the care of the mentally ill tuberculous and accepting patients from outside the county for such hospitalization.

The Division reiterates the desirability of establishing facilities for the care of the tuberculous mentally ill immediately adjacent to teaching institutions or other areas where psychiatric services are available so that adequate treatment can be given for both conditions simultaneously.

The success of modern surgery and drug therapy in tuberculosis has markedly reduced the bed occupancy of the state and county sanatoria. Many voluntary admissions are not remaining until they are entirely cleared of the infection. Many people are

falsely convinced that hospitalization is no longer necessary for TB.

Recognizing the need for institutional care in the chronic illness field, the legislature reacted to this situation with a statutory change permitting dual use of TB facilities having available beds. The question now comes: How can a dual facility be used safely and effectively?

The Division's proposed statement of policy concerning the dual use of county TB facilities has been approved by the Council and is submitted for action by the House of Delegates:

"PROPOSED STATEMENT OF POLICY RE: USE OF COUNTY TB FACILITIES

"With changed methods of therapy, the bed occupancy of county and state facilities for the care of the tuberculous has declined to a point where institutions are confronted with the alternatives of closing or accepting patients without tuberculosis to maintain sufficient bed occupancy to avoid undue cost to the taxpayers maintaining such facilities. The 1955 legislature passed a law to permit such dual use of facilities originally established to care for tuberculous patients alone.

"The Division on Tuberculosis and Chest Diseases is concerned with the application of this law to the detriment of the state-wide program on tuberculosis and has the following recommendations to offer:

1. "Before dual use of a single facility now being maintained for the care of the tuberculous is undertaken, the county boards of adjacent counties are urged to study the possibility of operating facilities so that each institution will limit its program to one disease, or to related diseases.
2. "In event that regional facilities cannot be developed as suggested above, it is recommended that patients without tuberculosis be selected carefully on the following basis:
   A. All patients be *hospitalized* patients.
   B. So far as possible patients with related chest diseases be assigned to county home beds in such dual facilities.
3. "If dual facilities are employed that the regulations of the State Board of Health be strictly enforced to avoid cross infection between groups housed in the same facility.
4. "Consideration should be directed to amendment of the present law so that the type of patients most suited for care will be indicated as to broad classification and that the selection of patients to be served shall be determined by the medical director of the sanatorium.
5. "The question of maintaining an open or closed staff of the county home portion be determined jointly by representatives of the county government and the county medical society."

The Division believes that, with state-wide physician cooperation and a linking of arms with the Division on Nervous and Mental Diseases, Wisconsin may be on the threshold of important accomplishment in the further demotion of the one-time captain of death.

SAVINGS PLANS FOR SIGHT AND SOUND

A REPORT OF THE DIVISION ON VISUAL AND HEARING DEFECTS

Maxine Bennett, M.D., Chairman; John Doolittle, M.D.; Howard High, M.D.; George Nadeau, M.D.; William Randolph, M.D.; C. G. Reznichek, M.D.; Meyer Fox, M.D. and F. J. Cerny, M.D.

Programs for the conservation of sight and hearing are finding increasing support throughout Wisconsin. Sparked by the Division on Visual and Hearing Defects during the past three years, these efforts have mushroomed to impressive proportions.

Case History No. 1:

Noise control became a major problem in industry when Wisconsin served as the testing ground for Workmen's Compensation claims based on hearing loss due to industrial exposure. One of the problems —how to determine the extent of hearing loss from employment. The Division offered its advice on hearing conservation, audiometric testing and hearing record keeping by producing a guide on "Hearing Conservation Programs for Wisconsin Industries." Since its publication in June, 1954, the simple eight-page booklet has become a best seller in medical and industrial circles. Requests from nearly every state have raised its distribution to more than 5,000 copies. A reprint, including late information on testing techniques, is being prepared and will be published by the time of the Annual Meeting. The Division is now concerned that strenuous efforts be directed toward providing physicians with more direct scientific education on the physician's role in supervising hearing conservation programs in industry.

Case History No. 2:

The Division, in 1955, developed "An Outline to Facilitate the Development of a School Vision Screening Program." The outline would permit the patient choice of physician or optometrist, but would not permit the optometrist to take an active part in the screening program itself as had been advocated by some optometrists. Developed in cooperation with a committee of optometrists, the outline has been widely circulated to both optometrists and physicians. The outline has produced successful screening programs in some areas and little but controversy in others. A committee of the Section on Ophthalmology and Otolaryngology has worked with a committee of the Wisconsin Optometric Society in

an attempt to iron out rough spots on problems arising in this field in Wisconsin. While the problem is far from solved, the Division believes that progress is being made. The Division has suggested some minor revisions in the outline for school vision screening programs and recommends that the Medical Society undertake a survey of Wisconsin to determine the availability of ophthalmological and optometric services. It is believed that the facts produced by such a study could be influential in improving the relations between the two groups.

Case History No. 3:

Tom Jones wasn't blind but neither could he see well enough to work. Reading was most difficult and enjoying the television was a virtual impossibility. Through the Division of Public Assistance Services to the Blind of the State Department of Public Welfare, he learned of the possibility that certain magnification aids might help him regain and maintain a certain degree of visual ability. He tried out the aids at the Agency's district office, discussed the matter with his ophthalmologist, and a set of magnification aids was prescribed which has since enabled Tom Jones to be employed in a gainful occupation and to enjoy certain social and entertainment functions. The Division on Visual and Hearing Defects has worked hand in hand with the Department of Public Welfare in the development of this optic aids program. As a result, kits of magnification aids are maintained in the Blind Agency's district offices; and those who think they can find some benefit from the aids are referred to the ophthalmologist of their choice for examination and instruction. If the aid can prove useful and the individual has financial hardship, the Agency can arrange the necessary financing. The Division has guided the development of this program and has cautioned against overoptimism among those who, having once been seriously visually handicapped, are inclined to seek with desperation a solution to their problem. In addition, the Division is working with the Blind Agency to develop statistical material relating to blindness in Wisconsin in the hope that its publication for the profession can be of considerable assistance to the conservation of vision in the state.

Recommendations

1. All physicians who serve in industry should make a special effort to acquaint themselves with the pamphlet on "Hearing Conservation Programs for Wisconsin Industries" so that they can properly assist management in the development of programs to provide employees with maximum protection against hearing loss and the assurance of adequate hearing evaluation and record keeping.

2. Physicians who believe that magnification aids may be of assistance to patients with serious visual handicaps are urged to contact, with the consent of the patient, the Division of Public Assistance Services to the Blind, 2385 North Lake Drive, Milwaukee, Wisconsin, for information on the location of the nearest kit of magnification aids. If the patient's ophthalmologist agrees that certain of the aids may be of benefit to the patient, they may be prescribed, if necessary, with the cost being borne by the Services to the Blind Agency.

3. All physicians are urged to acquaint themselves with the "Outline to Facilitate the Development of a School Vision Screening Program" so that school children can be assured of adequate screening programs and referral for follow-up care. Any problems arising out of such programs may be reported to the Division so that they may be handled in an orderly fashion.

4. A state-wide survey of ophthalmologic and optometric services should be undertaken so as to provide an adequate basis for future vision conservation programs.

5. Continued assistance in the school hearing conservation program conducted by the Bureau for Handicapped Children.

LET'S REVIEW OUR HANDICAP PROGRAM

A REPORT OF THE DIVISION ON CRIPPLED CHILDREN

Henry A. Sincock, M.D., Chairman; J. W. Nellen, M.D.; D. W. McCormick, M.D.; R. C. Waisman, M.D.; M. G. Peterman, M.D.; Kate P. Newcomb, M.D.; F. D. Bernard, M.D.; Patricia E. McIllece, M.D. and J. A. Beyer, M.D.

Twenty years ago, there were only 10 orthopaedists in Wisconsin. Now there are 48.

Twenty years ago the orthopaedic program of the Bureau for Handicapped Children of the State Department of Public Instruction was in its infancy. Last year 2,255 patients were seen in 36 clinics. Yet, today, the program operates on essentially the same policies as it did 20 years ago although certain important circumstances are markedly changed.

These facts are to be one of the important concerns of the Division on Crippled Children in its program for 1956–57.

The history of the Bureau for Handicapped Children is one of which Wisconsin can be proud. Since the State Medical Society has, through its Crippled Children Division, advised the Department from time to time and worked closely with it in the operation of the orthopaedic, rheumatic fever and hearing programs, the Society shares that pride.

After 20 years of successful programming in the orthopaedic field, the Division believes that the time has come to take a close look at the location of clinics, eligibility for service, attendance by new patients and returnees, public and professional informational aspects, and budgetary problems. It is thought that such a review might bring about better understanding of the program and, consequently, improved effectiveness. The Division requests that it be authorized to seek such a review with the cooperation of the Bureau for Handicapped Children.

Here are other facts of interest to physicians:

- ★ 18 orthopaedic field clinics are scheduled for the first half of 1956.
- ★ About 100 children in Wisconsin are currently known to have a loss of one or both arms.

Since June, 1955, such children have been eligible for referral by their family physicians to an Upper Extremity Prosthetic Clinic operated by the University of Wisconsin and the Bureau for Handicapped Children. If there is need, financial assistance is provided for purchase of appliances.

★ 107 children were born in 1954 with cleft palate and/or cleft lip. A majority of these children outside the Milwaukee area receive care at the Wisconsin Orthopedic Hospital, and the Bureau for Handicapped Children assists many financially.

★ 26 children attended cleft palate summer school in 1954 for speech rehabilitation.

★ 13,934 children received speech service in 1954 under supervision of the Bureau for Handicapped Children.

★ Special clinics have been held on delayed speech and stuttering and a Hearing Problems Clinic is scheduled for 1956.

★ Through family physicians, the Bureau has assisted needy persons with medical and surgical care costs ($5,000) and appliances ($12,000).

★ Last year, 341 patients visited the Wisconsin General Hospital Cardiac Clinic serving the state; 276 patients were seen at the St. Mary's Hospital Rheumatic Fever Clinic for Dane County and surrounding area; and 45 children were served through the Madison Kiddie Camp Convalescent Home for Rheumatic Fever.

Although the Division plans to review the rheumatic fever clinic programs of the Bureau for Handicapped Children and the Wisconsin Heart Association, it is generally of the belief that duplication of effort should be avoided through direct cooperation of physicians with area pediatricians and cardiologists and, if necessary, the Wisconsin Heart Association. It expects to report further on this matter in 1957.

THE MEDICAL SOCIETY'S BEST CROWD GETTER

A REPORT OF THE DIVISION ON SCHOOL HEALTH

E. H. Pawsat, M.D., Chairman; E. E. Bertolaet, M.D.; A. H. Heidner, M.D.; W. R. Manz, M.D.; F. J. Mellencamp, M.D. and C. Weir Horswill, M.D.

In a day when most people are "meetinged to death," there is one subject that never fails to draw a capacity crowd: School Health.

Dr. A. H. Heidner, West Bend, is shown addressing a panel group at the Conference on School Health in Milwaukee.

Nearly 3,500 teachers, parents, physicians, dentists, nurses and public health workers have turned out for seven school health conferences sponsored by the Division on School Health in the last four years.

More than 600 attended a two-county conference at Medford last October.

In spite of snow and icy roads, more than 260 showed up in La Crosse a month later.

Best of all, this meeting bonanza is paying off in terms of better health for Wisconsin's 550,000 school kids.

What's behind this splurge of interest in school health? The Division thinks there are two basic factors: One, the public's "discovery" of something doctors have long known—that good health during the school-age years aids the learning process and establishes lifelong habits of better living; and, two, a pattern of program planning that lets local people plan each conference the way they want it.

Supported by an annual budget of from $500 to $1,000, the Division enlists the cooperation of the Wisconsin State School Health Council, State Board of Health, Department of Public Instruction and the Department of Vocational and Adult Education in planning each session.

The Division insists on one basic procedure: local planning committees and local participation.

A 37-member committee planned the La Crosse conference. In Price–Taylor counties, schools closed for the day and attendance for all school board members was virtually compulsory.

Either Dr. E. S. Gordon or Dr. H. Kent Tenney of Madison has been a keynote speaker at each meeting. Audiences are literally spellbound by their presentations on the emotional and physical growth of children.

A half dozen workshop sessions, each lasting two hours, get to the heart of local problems. Competitive athletics always produces "fireworks." Coaches, teachers and parents are split in opinion on the value of interscholastic athletic programs, especially when football and basketball "take too much time of the children and put too much pressure on winning."

Other interesting panel papers have been (1) Health examinations; (2) Emotion disturbances; (3) Screening programs.

At every conference, there is obvious enthusiasm for more physical examinations and health services to be carried out in the physician's office. One nurse

summed up the feeling: "A close relation between the child and his personal physician can be a satisfying educational experience that encourages sound health practices which continue long after school days are over."

Here is what some of the conference participants have to say:

A physician: "If only a fraction of the things learned at the conference are put into effect, they are well worth the money."

A teacher: "The research of the medical profession pertinent to the classroom was most interesting. Now it is up to us to implement these findings in our schools. My suggestion: more conferences."

A parent: "I'm amazed at the interest of physicians in our problems and those of the teachers. These conferences are the doctors' best public relations."

While school health conferences steal the spotlight, the Division is tackling many other problems. It advises with the State Board of Health and the State Departments of Public Instruction and Vocational and Adult Education. The Division makes suggestions to the Wisconsin Interscholastic Athletic Association for the improvement of medical regulations governing the exclusion of athletes at the time of injury during competition. For example, the Division recently recommended that youngsters with hernias be prohibited from entering interscholastic athletic competition under the sponsorship of WIAA.

The Division is currently reviewing the iodine tablet program in Wisconsin schools to find out if equal results might be accomplished through the use of iodized table salt. A new study of the advisability of interscholastic athletic competition for youngsters under the 10th grade is now under way.

Meanwhile, the Division expects its school health conferences to keep their popularity rating for years to come. Next on the conference list are Platteville, April 12; Whitewater, October 11; and Superior, November 15. After that—more local conferences initiated by county medical societies to bring the school health message closer to home.

EDUCATION FOR REHABILITATION

A REPORT OF THE DIVISION ON REHABILITATION

Ray Piaskoski, M.D., Chairman; P. J. Collopy, M.D.; E. P. Roemer, M.D.; J. G. Beck, M.D.; C. C. Gascoigne, M.D. and R. W. Boyle, M.D.

"Rehabilitation" has tended to become a magic word in the medical vocabulary of professionals and laymen alike. That it is deserving of considerable attention is without question, but its importance should not be regarded with reverence and awe.

Like any other modality of medicine, rehabilitation needs to be properly understood before it can be effectively applied in the therapeutic regimen.

Since 1953, education for physicians and laymen has been the major effort of this Division. A rather extensive program of lectures, demonstrations, exhibits, talks to lay groups and publications has been arranged, sponsored and encouraged by the Division.

Typical of these efforts have been:

1. *A lecture on "Rehabilitation of the Severely Disabled Patient" before the annual meeting of the Neenah–Menasha Visiting Nurse Association.*
2. *Preparation of a paper entitled "An Evaluation of Some Electrodiagnostic Methods" for the annual session of the American Academy of Physical Medicine and Rehabilitation and its ultimate publication in the Archives of Physical Medicine and Rehabilitation.*
3. *A demonstration of rehabilitated veterans and a panel discussion on "Dollars and Cents Value of Employing the Physically Handicapped" as part of a conference on "Industry's Stake in the Handicapped" sponsored by the Marquette University Management Center in September, 1955.*
4. *A television program on "Employment of the Handicapped in Industry."*
5. *Addresses on geriatrics, community responsibility in rehabilitation, cardiac rehabilitation, sheltered workshop programs, arthritis, physical medicine, muscular dystrophy, poliomyelitis, backache, and ultrasonic therapy before the State Association of Rehabilitation Therapists, State Occupational and Physical Therapy Association, state and county industrial nurses associations, State Nurses Association, Wisconsin Dietetic Association, Neenah–Menasha Safety Council, and before groups of physicians in county medical societies, hospital administrators, industrial firms and local civic clubs.*

Exhibits on "Preventive Measures in the Management of Hemiplegia" and "Upper Extremity Amputations" will be presented at the Annual Meeting of the State Medical Society, May 1–3, 1956.

This type of educational program is viewed as a necessity by the Division, and it is recommended that such efforts be continued and expanded in the future.

In addition, the Division believes that certain other steps should be taken to make its work more effective:

1. **Greater coordination should be developed between the Division on Rehabilitation and other divisions of the Commission on State Departments so that the essential principles of rehabilitation can be applied to the solution of specific disabling conditions.**
2. **Serious efforts should be directed to public and professional recognition of "Employ the Handicapped" Week in Wisconsin.**
3. **Closer liaison should be developed between the Division of the State Medical Society and the Division on Rehabilitation of the State Department of Vocational and Adult Educa-**

tion so that its policies can be better interpreted to the profession.

4. **A special study of state and federal legislation, either proposed or newly adopted, should be undertaken in the field of rehabilitation.**

The Division hopes that its educational and advisory functions can be implemented in such a fashion during the coming year as to have a direct impact on the profession throughout the state.

Education and rehabilitation will bring understanding, and with that understanding will come progress.

AGING: TRIUMPH OR TRAGEDY?

A REPORT OF THE DIVISION ON GERIATRICS

A. M. Hutter, M.D., Chairman; M. T. Morrison, M.D.; M. J. Musser, M.D.; C. A. Olson, M.D.; Owen Otto, M.D.; George G. Stebbins, M.D.; Millard Tufts, M.D. and B. F. Eckardt, M.D.

"Dying old is the greatest triumph of the 20th Century . . . The phrase 'dying old' is a somewhat more realistic description of that triumph than to say that people now live much longer. Dying old implies that the function of the physician is to change the age and the cause of death, that birth is still a death sentence indefinitely suspended, and that the task is to suspend that sentence a little longer, and yet a little longer, and even yet a little longer. Dying old avoids the inference that a certain percentage of all deaths can be prevented."—*Frank G. Dickinson, Ph.D., Director, Medical Economic Research Bureau, American Medical Association, February 8, 1954.*

The person born in 1900 could expect to live 49 years. Today he could expect to live to age 70. That is the triumph. But the years that medical progress and better food, housing and sanitation have added to life can be tragedy unless they mean more than mere survival.

In Wisconsin, the spotlight is beginning to turn toward the problem of these later years, and the Division on Geriatrics is playing an important role in what will be revealed under the white light of public appraisal.

Governor Kohler has called the Conference on an Aging Population for June 6–7–8 in Madison. The State Medical Society is a co-sponsor. The chairman of the Division on Geriatrics and Dr. Allan Filek of the State Board of Health are responsible for preparing health and medical care portions of the program.

Three years ago, this Division recommended similar conferences. Now that it has been given official public endorsement, it behooves the medical profession to support it with substantial attendance and participation.

In addition to presenting factual and inspirational addresses, the conference will focus attention on these major areas of concern:

- ★ *Role of the county medical society in care of the aging.*
- ★ *Home care for aging and long-term patient.*
- ★ *Public health service in nursing home care.*
- ★ *The team approach to care of the aging.*
- ★ *Care of the senile.*
- ★ *How can we make effective use of institutions?*
- ★ *Making institutional living worth while.*
- ★ *Essentials of a community plan for the aging.*
- ★ *The church and the older person.*
- ★ *Employment of the older worker.*
- ★ *The older worker and retirement.*
- ★ *Leisure time and the older person.*
- ★ *Education for and about the aging.*

Three gentlemen very much interested in problems of the aged are shown in this picture. Busy mapping plans for the Governor's Conference on an Aging Population June 6–8 are (from left) Dr. Adolph M. Hutter, Fond du Lac; John Gillen, emeritus professor of the University of Wisconsin; and Dr. Allan Filek of Madison.

Obviously, physicians have deep concerns in each of these areas of the geriatric problem. All Division members are being asked to participate in some designated capacity on the program, but physicians throughout Wisconsin should take this opportunity to make their experience and knowledge felt in a conference that may have a significant influence on the future care of the aged in Wisconsin.

During the coming year, the Division proposes that it be given authority to explore means of focusing professional attention on the nutritional requirements of the aging, methods for assessing the health status of the aged, home care systems of medical and nursing care, and working with community agencies serving the needs of the elder citizen.

FOR PROFESSIONAL SERVICES RENDERED: $2,000,000

A REPORT OF THE DIVISION ON PUBLIC ASSISTANCE

H. W. Carey, M.D., Chairman; C. M. Carney, M.D.; C. A. Olson, M.D.; L. F. Morneau, M.D.; E. W. Schacht, M.D. and W. K. Simmons, M.D.

Last year the medical profession sent Wisconsin's public welfare agencies a bill for about $2,000,000. What did the agencies get for their money?

"Recipients of the social security aids in Wisconsin are fortunate in having a law wisely drawn to permit comprehensive treatment and rehabilitation, usually from a physician of the recipient's own choice.

"County agencies will be putting into effect within this year a uniform plan of procedures in making provision for medical care as it is broadly construed. This plan of 'Medical Care Standards' was issued by the State Department of Public Welfare after considerable study and counsel from the Division on Public Assistance of the State Medical Society, county welfare directors and others.

"We are heartened by the cooperative, consistent approach being made by the county welfare departments and local medical societies in responding to the directive of our legislature to develop a statewide plan for medical care. We recognize that in some instances both practitioners and agency staffs will have to devote real effort to achieving full understanding. These programs entail the expenditure of millions in public funds. Furthermore, there is continuing change and evolution. The situation commands careful attention and dedication to finding ways and means of doing what is best for all."

This comment from Wilbur J. Schmidt, director of the State Department of Public Welfare, pinpoints both problems and progress in the health care of dependent children, the blind, disabled, aged, and other types of public assistance recipients.

The total health care bill for general relief and social security aids in Wisconsin is currently in the neighborhood of $13,500,000, nearly $5,000,000 of which goes for hospital care. Physicians' care accounts for about 15 per cent of the total, or about $2,025,000 annually.

The problem is not made easier by the fact that expenditures for health care to social security recipients continue to rise in spite of a decreasing case load. They probably will keep on going upward, even though more and more persons are covered by old age and survivor's insurance and private retirement programs. The reason rests mainly with the aging of the population. More people are living to the age of retirement. More people live longer after retirement. With this aging process comes the greater expense of complicated, indefinite chronic illness. Thus, the increasing ability of aged people to care for their basic needs in food, clothing and shelter is offset by a financial inability to cope with the inevitable effects of physical and mental deterioration.

Wisconsin is far ahead of most states in its willingness to provide reasonably adequate assistance to those in need. It is equally far ahead in its administrative procedures for handling the social security aids and general relief, including such relations with the medical profession as direct payment to the vendor of health care.

This very progress, on the other hand, causes the Division to be especially alert to certain legislative developments on the national scene. Two bills (H. R. 9091 and H. R. 7225) and their counterparts in the Senate recognize for the first time federal matching of funds for direct payment to vendors. Their passage could mean as much as $2,000,000 annually in additional federal aid to Wisconsin's programs for the needy. H. R. 7225 raises to $65 the maximum public assistance grant in which the Federal Government would provide matching of funds, but it would do so with certain strings as to how the funds could be used. At the same time, its provisions might drastically affect benefits for the totally and permanently disabled.

It would appear to the Division that there is a distinct possibility that, with social security supplying the basic needs of the aged or needy persons, the future may see most state and federal funds being used primarily to provide health care. In that event, the Division wonders whether federal authorities might not be tempted to undertake direct health care programs, first, to help the needy, then, later, for the general population.

The Division cites this legislation and these trends because it believes Wisconsin's admirable public welfare programs should be protected and preserved as local responsibilities. They should not be permitted to slip backward merely to conform to a federal mould.

Clearly on the side of progress during the past year was the development, in cooperation with the Division on Public Assistance, of the medical care standards known as Chapter V of the State Department of Public Welfare.

Chapter V sets forth rules and regulations under which county social security agencies can establish procedures for the payment for health care for recipients. Physicians, seeing the 70-page manual for the first time, are prone to consider the material "bureaucratic." Actually, most well-functioning county welfare departments have had a similar collection of regulations for many years.

The legislature was the motivating force behind the development of Chapter V. Recognizing the state's financial responsibility in the care of the needy, the legislature was primarily interested in assuring relatively equal consideration for the general welfare of all patients, their recovery and rehabilitation. Most important, the state recognizes in this new guide for welfare departments the essential role of the physician in helping to achieve these objectives. To provide better physician understanding of the intent of Chapter V, the Division presents a series of questions and answers.

Will physicians be consulted in county programs?

Yes. Several counties have long had medical committees to advise, consult or audit. The committee plan has proved to be of much value to physicians and county welfare agencies. The guide contains recommended and suggested methods of working together. Some definite plan is expected in each county, and the physicians are to help set up the county plan. Some plans are already working and may need no change. In some places, improvement may be indicated.

What is required on fee schedules?

The county and the physicians develop the schedule of fees and services. All of the common services should be covered, and there should be some definite method of taking care of unusual situations. The state does not set fees, nor does this chapter make any provision for establishment of a state-wide schedule.

Are physicians going to have a lot of forms to fill out?

Neither the state nor the counties want any unnecessary forms and paper work. The forms are actually quite simple; and in the majority of cases, the county will expect only a billing along with some brief information about the condition requiring treatment.

Will physicians be protected in giving out medical information about patients?

In response to the request of the Division of Public Assistance, each county agency will obtain the written consent of each patient-recipient for release of medical information to the county agency. The doctor will not have to fill out any forms or take time to participate in obtaining this consent.

The Division on Public Assistance is pleased that, in most counties, the welfare agency and the medical society are proceeding in a cooperative, orderly manner to develop a medical care plan within the state-wide standards. In most instances, the first step has been taken in becoming familiar with the objectives and requirements. Progress in actually negotiating a plan is under way with activity in virtually every county. The State Department of Public Welfare believes that the new plans will be in operation by July 1 in many counties.

WARNING: CURIOSITY AT WORK

A REPORT OF THE DIVISION ON SAFE TRANSPORTATION

R. S. Gearhart, M.D., Chairman; Marvin Wright, M.D.; G. H. Anderson, M.D.; D. H. Hinke, M.D.; Milton Trautmann, M.D.; James C. H. Russell, M.D. and Charles E. Hopkins, M.D.

Curiosity may have killed the cat, but the Division on Safe Transportation hopes to use it to save lives.

The problem: How important is the health factor in automobile fatalities?

Shocked by the fact that state traffic deaths reached a new high in 1955 and are still on the way up in 1956, the Commission on State Departments set up a separate division to probe the health aspects of modern transportation.

Death statistics quite obviously haven't scared people into safer driving habits. The Division is interested, however, in analyzing accident data to answer such questions as these:

- ★ Is imperfect health—including such things as diabetes, heart failure, visual and hearing defects, and sclerosis—the cause of any significant number of auto accidents?
- ★ Do such diseases call for closer regulation of automobile drivers? Of truck drivers?
- ★ How much do mental attitudes—anger, fear, exuberance, sadness—contribute to accidents?
- ★ Are tinted windshields dangerous? More so for oldsters than young people?
- ★ Is there need for certain driving restrictions on youngsters or the aged or both?
- ★ Are physicians alert to improved methods of handling traumatic injury?
- ★ What can be done about such major accident causes as errors in judgment, speed and alcoholism?
- ★ If accidents can't be prevented, how can their killing effect be reduced—safety belts, crash-resistant bodies, safer interior construction?

The Division is curious about other matters, too:

- ★ Are the state's crash injury report forms requiring physicians to attest to "hearsay" evidence not always related to medical findings?
- ★ Should applicants for a Wisconsin driver's license be required to sign a permit to allow blood test in event of arrest?

These are a few of the things a curious committee plans to look into. Who knows, its research may produce an antitoxin for accidents.

A DIVISION REGROUPS FOR ACTION

A REPORT OF THE DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. Schwade, M.D., Chairman; E. M. Burns, M.D.; Roland Jefferson, M.D.; Keith Keane, M.D.; A. A. Lorenz, M.D.; Leslie A. Osborn, M.D.; J. T. Petersik, M.D.; Henry Veit, M.D.; Chester Wade, M.D.; Charles Wunsch, M.D.; Walter Urben, M.D.; and J. R. Hurley, M.D.

Subcommittee on the Disturbed Child:
Roland Jefferson, M.D., chairman; Sara Geiger, M.D.; Owen Otto, M.D.; Robert O'Connor, M.D.; A. A. Lorenz, M.D.; James Vedder, M.D.; W. C. Lewis, M.D.; L. M. Simonson, M.D.; and E. D. Schwade, M.D.

Subcommittee on Medical Residencies:
Chester Wade, M.D., chairman; H. H. Reese, M.D.; Horace K. Tenney, III, M.D.; Keith Keane, M.D.; William Bleckwenn, M.D.; Leslie Osborn, M.D.; and E. D. Schwade, M.D.

Subcommittee on Clinical Psychologists:
E. D. Schwade, M.D., chairman; Saul Pollack, M.D.; Chester Wade, M.D.; T. J. Nereim, M.D.; and E. M. Burns, M.D.

The Division on Nervous and Mental Diseases has just concluded a six-year campaign with victories for the epileptic and the mentally diseased. Now it is preparing for new expeditions in the field of mental health and institutional care.

This militant approach to a major health problem is producing results:

1949—Legislature approves "temporary" driver's permits for epileptics under medical control.

1951—Legislature passes a law to encourage the building of county infirmaries for the aged, some of whom have mental disease.

1953—Legislature legalizes marriage among epileptics.

1955—Legislature adopts Division's proposals for more orderly and humane detention of mentally diseased persons and releases the epileptic from the stigma of mental illness.

While the Division may seem to have earned a rest, it finds itself occupied currently on four fronts:

Clinical Psychology—"Certification and registration of persons in Wisconsin representing themselves as psychologists" seems in the offing. The AMA at Boston in December, 1955, opposed licensure for psychologists but sidestepped a position on certification or registration. Since psychology is a part of medical practice, its definition as a separate entity is difficult. It may lead only to another fragmentation of medicine by legislation.

Epilepsy—A comprehensive survey of epilepsy in Wisconsin is being undertaken by the Rehabilitation Division of the State Department of Vocational and Adult Education in cooperation with the Division on Nervous and Mental Diseases. All physicians are urged to cooperate in completing and returning the simple, brief reporting forms. The study may provide highly valuable data for the social and industrial restoration of epileptics.

Tuberculosis—Nowhere in the state is there a better opportunity to strike a telling blow at TB than in the mental institution. In this well-defined group, there is high incidence; high mortality; and at present, great danger for infection and reinfection. The Division is closing ranks with the Division on Tuberculosis and Chest Diseases to deal with this problem immediately.

Voluntary Groups—A new element of Division activity has emerged with appeals from at least three major lay groups in the mental health field for medical advice. The Division is, therefore, developing closer liaison in an advisory capacity with the Wisconsin Association for Mental Health, United Cerebral Palsy of Wisconsin and the Institute for the Slow Learner.

The Division's big push, however, is a two-pronged attack aimed at the disturbed child and the medical care in county mental institutions. A guide for medical directors of county hospitals is already in preparation. However, the Division recommends that it be given authority to proceed with:

1. **A manual for judges to acquaint them with specific procedures and facilities for better handling of children with severe emotional disorder.**
2. **A special study of treatment programs for the disturbed child, with emphasis on proper use of facilities at Sparta and Northern and Southern Colonies; further development of child guidance centers; and the development of adequate facilities for psychiatric and pediatric services and training programs in relation to hospitals and centers of medical education.**

IS HOME TOWN CARE FOR VETERANS DOOMED?

A REPORT OF THE WISCONSIN VETERANS MEDICAL SERVICE AGENCY OPERATING COMMITTEE

J. S. Supernaw, M.D., Chairman; O. A. Dittmer, M.D.; Maurice Hardgrove, M.D.; W. A. Fischer, M.D. and C. E. Koepp, M.D.

"I have concluded therefore that it will serve the best interests of state medical societies, veterans and the Government to terminate all existing contracts with the intermediaries no later than July 1, 1957." (William S. Middleton, M.D., chief medical director, Veterans Administration)

Thus the VA announced its intention to conclude its ten-year agreement with the State Medical Society of Wisconsin for home town care of veterans with service-connected disabilities.

Seven other states where the medical society or Blue Shield plan acts as intermediary received the same notice. The reason? The VA in the termination notice said, "In recent years, the Home Town Care Program has become well stabilized with the result that the need for intermediary arrangements has diminished progressively. Current survey reports demonstrate that, under this third-party type of operation, there is much unavoidable duplication of effort."

Citing payments of more than $350,000 in 1955 to the eight intermediaries for administrative costs, Doctor Middleton concluded, "It is evident that a more efficient operation would result through elimination of such third-party agreements."

Does this mean the end of home town care for veterans? The VA says not. The Wisconsin Veterans Medical Service Agency Operating Committee and similar groups in other states say, "It could mean that a lot of veterans would suffer."

Doctor Middleton proposes that the VA contract directly with physicians to provide fee-basis care for eligible veterans under the same fee schedule that is now in effect. It is assumed that this plan would produce the same net results as the intermediary agreement.

But will it? Many intermediaries contend that the VA couldn't enlist the support of nearly so many physicians as participate through their system. Wisconsin, for example, has about 70 per cent of its member physicians participating in the WVMSA program. As for service to veterans, in some states where the VA deals directly with physicians outpatient services are reported to be 50 per cent lower than under intermediary plans.

With fewer participating physicians to attend their needs, veterans may find it necessary to travel long distances to VA regional offices. This will produce a loss of work and wages and possibly considerably increased costs to the Federal Government.

The intermediary program also brings with it valuable services in the way of education and interpretation to physicians and veterans, elimination of "red tape" to the satisfaction of doctors and veterans, and a considerable ability to self-regulate which is unavailable to the VA if it handles the program on a direct basis.

The WVMSA Operating Committee has not committed itself to an answer to the VA as yet, and the matter is to be given further detailed attention by the Council in the future.

During 1955, authorizations received by the Wisconsin Agency from the Veterans Administration for Home Town Care totaled $142,847.05. In the previous year, 1954, the authorizations totaled $143,-215.53. From the time of its inception to March 1, 1956, the program resulted in the payment of $1,658,299.65 to physicians for services rendered to eligible veterans.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

A Division of the State Medical Society of Wisconsin
Madison, Wisconsin

CERTIFIED FINANCIAL STATEMENT
June 30, 1955

ASSETS

Current Assets		
Cash in Bank—Administrative Fund	$5,542.78	
Administrative Claims Filed with Veterans Administration	1,243.60	
Medical Claims Filed with Veterans Administration	4,824.50	
Unfiled Claims	50.62	
Total Current Assets		$11,661.50
Fixed Assets		
Office Furniture and Fixtures	$2,434.17	
Less: Accumulated Depreciation	1,720.55	
Total Fixed Assets		713.62
TOTAL ASSETS		$12,375.12

LIABILITIES

Current Liabilities		
Cash in Bank—Medical Fund (Overdraft)	$1,543.50	
Due Doctors on Claims Filed	3,281.00	
Accounts Payable	50.62	
TOTAL LIABILITIES		4,875.12
Advance from State Medical Society of Wisconsin		
Balance of Cash Advance—June 30, 1955		$ 7,500.00

Certificate

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, a Division of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1955, to June 30, 1955, and

I hereby certify that, in my opinion, the above Financial Statement . . . [presents] fairly the financial condition of the Agency on June 30, 1955, . . . in conformity with generally accepted accounting principles.

Madison, Wisconsin
August 19, 1955

Certified Public Accountant
DONALD E. GILL

Excerpts from Report of the President

President Ervin L. Bernhart: Needless to say, as each successive president has informed you gentlemen, this year has been a busy one. The president of the State Medical Society, when elected to that office, can expect to expend 50% of his time and energy in duties involving his official position. To a busy normal practice of approximately sixty hours a week, a president can expect to add twenty hours for official duties. About twenty hours of the normal sixty will be devoted to presidential responsibilities. Thus, an eighty-hour week becomes divided into forty hours for the practice of medicine and forty hours for official duties.

At committee meetings, county society meetings, and annual conventions of our neighboring state medical societies, matters of public health, medical progress, and medical economics are discussed for the benefit of all. For me, it meant a total of 87 days in attendance at these meetings.

I also had the privilege of representing the 3,300 physicians of our State Medical Society at the annual meetings of the state societies of Illinois, Minnesota, and Indiana, and at the Northwest Conference of Medical Societies, which includes six Midwestern states. Not only do these visits fulfill our so-called "diplomatic duties," but they are valuable from the standpoint of an exchange of information, experiences, and ideas within the area of our many mutual medical organizational endeavors.

I am indebted to the officers, Councilors, and committeemen for their deep devotion and interest to the tasks which have been assigned to them. I am sure that each individual assigned to a commission or a committee expended his greatest effort for the benefit of our Society.

As those of you know who have served as committeemen, Councilors, or officers, we can never bestow sufficient thanks to our very fine staff. The invaluable assistance of Charlie Crownhart and his staff makes the seemingly insurmountable task of running a State Medical Society possible. I know you all join me in this expression of appreciation to Charlie's entire staff. This meeting attests to the fine teamwork of our State Society headquarters personnel.

It has always given me a feeling of satisfaction to see the excellent cooperation exercised by the staff of the State Medical Society and that of the Medical Society of Milwaukee County at these annual meetings. There can be no doubt about how fortunate we in Wisconsin medicine are to have the

facilities of two such fine medical organization headquarters within the same state.

Last October 15, I performed a task as your president that was a great honor. Along with many distinguished guests, I assisted in the dedication of our new State Society "home." Many of you have visited our new headquarters during the past year and know first-hand of the fine new office facilities our Society now has. Those of you who have not had an opportunity to go to Madison to visit Charlie in his new "Bar and Grill" should do so. It's well worth the trip to see your efficient State Society headquarters staff in action.

That the organization of our State Medical Society has grown is an understatement indeed. Our new headquarters houses not only the activities of our membership, the committees, the commissions, and the Council, but also the many duties involved in publishing *The Wisconsin Medical Journal;* organizing our well-planned Annual Meeting; and administration of our voluminous activities in the fields of public health, public relations, postgraduate education, Physicians' Placement Service, Veterans Medical Service, Student Loan Fund, and probably one of the most important, Wisconsin Physicians Service, our Blue Shield plan.

Developments in Health Insurance Field

It is indeed significant that our Blue Shield plans in the state, Wisconsin Physicians Service and Milwaukee Surgical Care, now offer protection to 754,000 persons. Their companion plan for hospital protection, Blue Cross, covers 932,000 in Wisconsin. Nationally, Blue Shield gives 35 million people medical protection and surgical coverage. Blue Cross now has 51 million members; it has been said that this is the largest number of persons ever joined together voluntarily for one single purpose in the history of the world. Blue Shield, as you can see, is not far behind.

To digress for a moment—I served at another historic occasion in relation to a new building, that of the new Blue Cross headquarters now being built near West Capitol Drive and North Teutonia Avenue in Milwaukee. This modern three-story structure will offer much-needed and larger facilities for the servicing of the 932,000 Wisconsin Blue Cross subscribers. Our congratulations to Blue Cross for this forward step—another on the successful road of progress in the field of prepaid medical care.

As all of you have observed in your practices through the last quarter century, there has been increased activity in the field of health care. We have seen more individual voluntary prepayment medical care and services. There have been more group arrangements made for such services. More unions or cooperatives are handling health problems. There are more lay-controlled groups sponsoring health care plans and services. There has been a general increase in the public's health consciousness and in what can be done to make the nation's health better. These are only a few of the changes in the field of health care today.

As evidenced by the tremendous growth of our own Blue Shield plans, the field of voluntary health insurance shows one of the greatest changes.

A major development in the changes in Blue Shield coverage is exemplified within our Wisconsin Physicians Service plan with the offering last year, for the first time, of a full service-benefit concept in prepaid medical care.

All of you are familiar with the contract, which now covers over 5,000 persons in several major groups in the state. The plan functions without a fee schedule. Instead of a fee schedule, a statement in the contract reads, "The plan will pay the customary, usual and reasonable charges for professional services." It is further clarified: "A charge will be deemed customary, usual and reasonable if it does not exceed the general level of charges by other physicians who render such services under similar or comparable circumstances within the community in which such charge is incurred."

To my knowledge, Wisconsin is a true pioneer in this respect. I know of no other plan offering similar benefits to its Blue Shield subscribers.

We feel that this program preserves those features which the medical profession must consider to be essential in a good prepaid medical plan. They are free choice of physician, control by the medical profession, preservation of physician-patient relationship, fee-for-service payment, availability of full medical resources, and most complete financial coverage within financial stability.

This experimental program is being observed carefully and examined by Blue Shield plans and other health insurance programs throughout the nation from day to day. While the plan appears to be workable, extreme caution in its further development must be exercised. We can continue to learn as we go—but doing so cautiously.

Four of the more important subjects that have come before our Medical Society during the year I served as president are the poliomyelitis vaccine, H.R. 7225 dealing with the extension of social security benefits, rural health, and traffic safety.

Poliomyelitis Vaccine

Physicians all over the United States have been besieged by anxious parents who want the vaccine against poliomyelitis by Doctor Salk for their children. In Wisconsin our Society established a Salk Polio Vaccine Emergency Consultation Committee to handle the problem. The State Board of Health is purchasing the vaccine supplies with funds allocated to it by the Federal Government.

I am proud to report that Wisconsin physicians have demonstrated that they can and do provide Salk vaccine antipolio injections, regardless of the ability to pay, in the true tradition of the American practice of medicine. While the term "free" vaccine is used so loosely by all of us and the public, it might be well to stop for a moment occasionally to remember that the "free" vaccine was actually purchased by the taxpayers' hard-earned money. It is "free" through taxation.

We received a letter from the National Foundation for Infantile Paralysis from Dr. Hart Van Riper, one of our own Wisconsin men. It reads as follows:

April 25, 1956

"Dear Dr. Bernhart:

"May I take this opportunity to express thanks from the National Foundation for Infantile Paralysis to the State Medical Society of Wisconsin as a whole and to its individual members for their excel-

lent cooperation with the State Health Department and the National Foundation in the successful conduct of the poliomyelitis vaccine demonstration program in Wisconsin during 1955.

"The chief beneficiaries of this program, of course, were the Wisconsin school children, mainly in the first and second grades, who received one or more injections of vaccine supplied by the National Foundation during the year 1955. A total of 216,009 cc. of vaccine was supplied.

"You may be interested to know that, thanks to your help, 95,649 Wisconsin children received at least one inoculation; 79,881 received two inoculations, and 5,691 received a third (booster) inoculation up to December 1, 1955.

"Approximately 30 per cent of the Wisconsin children in the 5–9 age group, the age group most susceptible to paralytic poliomyelitis, thus obtained a high degree of protection against the disease in 1955 as a result of this program.

"The cooperation of the State Medical Society of Wisconsin helped materially to account for this fine record.

"While this is a formal expression of gratitude for your help, the real expression must come from the parents of those many children in Wisconsin who feel free from the threat of paralytic poliomyelitis in their families now that the 1956 poliomyelitis season is at hand.

/s/ Hart E. Van Riper, M.D.
Medical Director

Social Security Bill

The next point I wish to make concerns the social security bill, H.R. 7225, which would among other things extend coverage, reduce the retirement age for women, and approve payments for disability. Mr. Robert B. L. Murphy, our capable and alert legal counsel for the State Medical Society, was one of 100 national figures to appear before the hearing committee on this bill. His testimony left a definite impression on the committee as to the position of the State Society representing the medical profession in Wisconsin.

We were pleased to note Secretary Folsom's testimony. Appearing as the final witness in the hearings, Mr. Folsom expressed the administration's clear-cut stand on H.R. 7225 by opposing the reduction of the retirement age for women and payments for disability. He told the Senate committee that, while he was in favor of supporting a strong and sound system of economic security, he thought that Congress would be endangering rather than strengthening the program by enacting the provisions in question. After careful and prolonged study of this situation, we can certainly be in accord with this philosophy.

Rural Health

I believe a few words on the subject of rural health are in order in this report. Wisconsin is proud to continue as one of the pioneers in rural health planning. The eleventh National Conference on Rural Health in Portland, Oregon, last March, sponsored by the American Medical Association, covered many problems common to rural communities and areas such as those in our predominantly agricultural state.

It is encouraging to note more and more practicing physicians taking an active part in this planning, supplementing the activity of those physicians in administrative capacities. The relationship of the family and the physician provided the primary topic at the Portland conference. Of interest to all physicians, not only those in the rural areas, was the emphasis placed on the family doctor's part in mental health and care of the aged, his responsibility to patients and the community, and their responsibility to him.

Again, I wish to repeat the encouraging trend of more and more practicing physicians expressing an interest in these mutual public health problems, and am gratified to see our many busy colleagues throughout the State of Wisconsin successfully filling the role as "hub" for many community activities and programs, many of which are not even directly related to health. Under the guidance and continued encouragement of our new president, I know that this trend will continue to increase and to reflect favorably upon the medical profession as community leaders.

Traffic Safety

Turning to another major public problem in the realm of medicine and health, I would like to close this report with some remarks on accident prevention. The situation is serious. You have heard it thousands of times; but what can we do?

A young Milwaukee physician is convinced he is alive today because his automobile was equipped with safety belts when it crashed accidentally March 1 of this year. He might not have lived to tell his story if he had not had the foresight to have his automobile equipped with safety belts.

I wish to give recognition to a step in the right direction in the over-all program of accident prevention as applied in Milwaukee County. It is only a small step; but with all individuals and agencies interested in participating, it is a project that many of you may be able to develop in your own communities.

This particular plan to which I refer is the Poison Control Project of the Medical Society of Milwaukee County, instituted by the Milwaukee Academy of Pediatrics in cooperation with the City Health Department, Marquette University, the county institutions, and several hospitals.

In the future, all Milwaukee hospitals will be participating in the new pilot plan. I won't delve into the mechanics of the operation of the poison control centers; but I will tell you they are doing a unique job, receiving national recognition, dealing with the prevention and treatment of accidental poisonings and with an important follow-up program of family education and the compilation of heretofore nonexistent statistics on the incidence of the types of nonfatal accidental poisonings, especially in children. The committee had the foresight to use this Poison Control Project as a model for future planning, encompassing other types of accidental injuries. It is a plan that may be one answer to our shameful accidental death toll. It deserves support and encouragement.

Regarding a second phase of the accident problem, I want to propose a recommendation for the future administration of the State Society. I recommend that the State Medical Society undertake a campaign among the 3,300 physicians of Wisconsin, promoting the installation of automobile safety belts in every physician's automobile. By this example of the medical profession, I am sure much can be done to support the existing programs being carried out by community service groups promoting the use of automobile safety belts.

Our goal should be **A Safety Belt for Every Physician's Automobile**, and the plan should have the support of every physician in the State of Wisconsin.

Once again, my sincere thanks to all of you who have given me assistance, encouragement, and support while I was serving as your president.

Report of the President-Elect

The report of the president-elect, Dr. L. O. Simenstad of Osceola, was published in the June issue of *The Wisconsin Medical Journal.*

On motion of Dr. G. W. Carlson, Appleton, seconded by Dr. E. D. Sorenson, Elkhorn, carried, the following committee appointments of the president-elect were approved:

Committee on Cancer

Dr. Carlton Wirthwein, Milwaukee
Dr. W. S. Bump, Rhinelander
Dr. G. I. Uhrich, La Crosse
Dr. J. W. Conklin, Platteville
Dr. Ralph C. Frank, Eau Claire
Dr. R. J. Schacht, Racine
Dr. R. C. Cantwell, Shawano, chairman for 1956–1957.

Committee on Coordination of Medical Services

Dr. S. E. Gavin, Fond du Lac
Dr. R. S. Gearhart, Madison, chairman for 1956–1957.

Committee on Grievances

Dr. E. W. Mason, Milwaukee
Dr. E. D. Sorenson, Elkhorn
Dr. J. L. Moffett, Platteville
Dr. R. E. Fitzgerald, Milwaukee, chairman for 1956–1957.

Committee on Hospital Relations

Dr. W. C. Henske, Chippewa Falls
Dr. S. W. Hollenbeck, Milwaukee
Dr. W. B. Hildebrand, Menasha, Chairman for 1956–1957.

Committee on Medical Education and Hospitals

Dr. T. L. Squier, Milwaukee
Dr. Squier, Chairman for 1956–1957.

Council on Medical Service

Dr. C. J. Picard, Superior
Dr. E. C. Cary, Reedsville
Dr. J. F. Maser, Rice Lake
Dr. J. S. Devitt, Milwaukee, chairman for 1956–1957.

Committee on Public Policy

Dr. A. A. Quisling, Madison
Dr. J. M. Sullivan, Milwaukee, Chairman for 1956–1957.

Council on Scientific Work

Dr. M. C. F. Lindert, Milwaukee
This committee to select its own chairman.

Report of the Treasurer

Dr. F. L. Weston, treasurer, presented the treasurer's report, which relates only to those operations of the Society which are the direct responsibility of the treasurer.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin

FINANCIAL STATEMENT
December 31, 1955

ASSETS		
Cash on Hand and in Banks		$ 30,805.46
Due from Divisions of State Medical Society—Current	$ 9,458.92	
Due from Student Loan Fund	519.12	
Accounts Receivable—Physicans, Employees, and Others	615.15	
Guaranty Deposit	425.00	
Total Receivables		11,018.19
Working Capital Advances		
Wisconsin Medical Journal	$ 13,409.86	
Wisconsin Veterans Medical Service Agency	7,500.00	
Total Advances		20,909.86
Furniture and Equipment	$ 33,598.05	
Less: Accumulated Depreciation	17,491.16	
Total Depreciable Assets—Net		16,106.89
Prepaid Expenses and Deferred Charges		1,873.56
TOTAL ASSETS		$ 80,713.96
LIABILITIES		
Vouchers Payable	$ 12,297.04	
Due American Medical Association	95.00	
Dues—Suspense	234.00	
Prepaid Membership Dues	11,364.00	
Prepaid Exhibit Space Rentals	5,202.50	
Prepaid Postgraduate Clinics	600.00	
Deferred Income	675.00	
TOTAL LIABILITIES		30,467.54
NET WORTH		
Surplus—General Fund	$ 34,576.51	
Net Worth of Wisconsin Medical Journal	13,409.86	
Surplus Reserved for New Building	1,075.00	
Surplus Reserved for Section on Medical History	1,185.05	
TOTAL NET WORTH		$ 50,246.42

CONDENSED STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1955

INCOME

Administrative and General Income		
Membership Dues—Current Year	$175,734.50	
Membership Dues—Prior Years	1,212.00	
Total		$176,946.50
Other Income		
Public Health Information	$ 10.00	
Annual Meeting	18,306.00	
Clinics and Meetings	3,505.00	
Section on Medical History	710.00	
Cafeteria	8,218.05	
Miscellaneous	2,735.21	
Total		33,484.26
Total Income		$210,430.76

EXPENSES

Administrative and General Activities		
Executive Staff Salaries	$ 38,950.00	
Other Salaries and Wages	41,786.86	
Council, Officers, Delegates and Committees Expense	14,930.58	
All Other Administrative and General Expenses	59,254.48	
Total		$154,921.92
Other Expense		
Public Health Information	$ 9,903.61	
Annual Meeting	16,765.61	
Clinics and Meetings	4,294.26	
Interim Appropriations	4,335.55	
Cafeteria	9,665.40	
Total		44,964.43
Total Expense		199,886.35
Excess of Income over Expense		$ 10,544.41

DETAILED STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1955

INCOME

Administrative and General Activities			
Membership Dues—Current	$175,734.50		
Membership Dues—Delinquent	1,212.00	$176,946.50	
Office Service		1,910.00	
A.M.A. Collection Service		718.02	
Miscellaneous Income		107.19	
Total			$179,681.71
Public Health Information			
Medical Service Panels			10.00
Annual Meeting			
Exhibit Rentals		$ 16,545.00	
Round Table Receipts		1,761.00	
Total			18,306.00
Clinics and Meetings			
Health Conferences		$ 421.00	
Postgraduate Teaching Clinics		3,084.00	
Total			3,505.00
Other Income			
Section on Medical History		$ 710.00	
Cafeteria		8,218.05	
Total			8,928.05
Total Income			$210,430.76

Balance brought forward			$210,430.76
EXPENSES			
Administrative and General Activities			
President's Travel	$ 1,500.00		
Council, Officers, Delegates and Committee Meeting Expense	14,930.58		
Association Dues	910.80		
Resource and Informational Material	846.84		
Woman's Auxiliary	868.63		
Accounting	2,386.17		
Insurance	284.26		
Rent	12,000.00		
Telephone and Telegraph	1,854.66		
Printing and Office Supplies	6,721.20		
Postage and Express	4,114.57		
Section on Medical History	161.60		
Upkeep and Fixtures	1,037.03		
Depreciation	3,049.94		
Legal Expense	5,479.00		
General Bulletins to Members	657.38		
Blue Book Issue	2,000.00		
Executive Staff Salaries	38,950.00		
Other Salaries and Wages	41,786.86		
Payroll Taxes	1,605.33		
Group Insurance Expense	1,091.62		
Retirement Program	3,328.85		
Staff Travel Expense	7,629.77		
Loss on Disposal of Fixed Assets	218.98		
Miscellaneous Expense	1,507.85		
Total			$154,921.92
Public Health Information			
Telephone and Telegraph	$ 92.07		
Today's Health	468.00		
Legislative Counsel	4,200.00		
Press Releases and Services	250.05		
Health Conferences, Exhibits and Publications	1,210.60		
March of Medicine Expense	2,505.66		
Miscellaneous Expense	1,177.23		
Total			9,903.61
Annual Meeting			
Woman's Auxiliary	$ 500.00		
Insurance	10.00		
Auditorium Rental and Labor	2,004.55		
Expenses of Speakers	2,759.57		
Publicity and Program Expense	780.26		
Union Operation	243.10		
Scientific Exhibits	853.19		
Commercial Exhibits	2,367.20		
Stenotype Record	201.18		
Round Tables, Dinner, President's Reception and Guest Luncheon Expense	3,078.78		
Badges	234.26		
House of Delegates Expense	986.61		
Postage	300.00		
Machine Rentals	207.40		
Staff Expenses	1,566.04		
Miscellaneous Expense	673.47		
Total			16,765.61
Clinics and Meetings			
Postgraduate Teaching Clinics	$ 3,169.03		
Special Conferences	1,125.23		
Total			$ 4,294.26
Interim Appropriations			
Wisconsin Medical Journal	$ 3,600.00		
Wisconsin Veterans Medical Service Agency	735.55		
Total			4,335.55
Cafeteria			
Depreciation	$ 192.23		
Salaries and Wages	3,543.07		
Payroll Taxes	116.97		
Group Insurance Expense	86.76		
Food Purchases	4,394.41		
Beverage Purchases	1,071.65		
Miscellaneous	260.31		
Total			9,665.40
Total Expenses			$199,886.35
Excess of Income over Expense			$ 10,544.41

RECONCILIATION OF NET WORTH
December 31, 1955

Net Worth—December 31, 1954		$109,197.57
Deduct: Subsequent Audit Adjustments		1,388.20
Adjusted Net Worth—December 31, 1954		$107,809.37
Additions:		
Excess of 1955 General Fund Income over Expenses, Including $548.40 Relating to the Section on Medical History	$ 10,544.41	
Donations Credited to Reserve for New Building	1,050.00	
Increase in 1955 of Net Worth of the Wisconsin Medical Journal	6,808.81	
Total Additions		18,403.22
		$126,212.59
Deductions:		
Transfer of Gorham Street property to SMS Realty Corporation	$ 68,966.17	
Transfer of Capital to SMS Realty Corporation	7,000.00	
Total Deductions		75,966.17
Net Worth—December 31, 1955		$ 50,246.42

Report of the Secretary

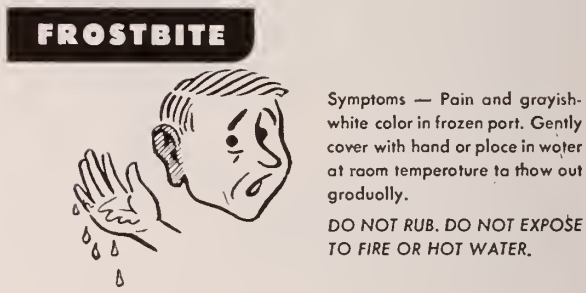
The following report of the secretary was published in the *Annual Report for Delegates.*

THE NEW LOOK

Boring details, stereotype phrases, overly long reports . . . these are all the termites that often prevent proper consideration of matters coming before the House of Delegates. This year the new look is their elimination, and this report endeavors to follow suit.

Implementation of policies and projects determined upon by the Council, the House of Delegates and other organizations within the Society is the prime responsibility of the secretary's office. Their accomplishment is not always easy. Many of them are related directly in the various reports published in this handbook. But illustrative of others in the hopper at the current moment are the following of real interest to every member of the Society.

This familiar trademark is that of many of our machines now in the new building. Begun in 1954, hampered by lack of space in the old building, and scheduled for production in 1956 are statistical studies relative to physicians in Wisconsin. As these studies accumulate in future years, it is hoped that patterns of practice and problems can be discerned, and where not in sound public health interest, solutions proposed. These studies will relate location by age, by school of graduation, by type of practice, and the frequency of new and re-locations within the state.



Here is one of the twenty illustrations contained in the First Aid chart prepared in a two-color poster for the inside of the medicine cabinet door. Its final preparation entailed many conferences, and its success has been outstanding. More than 50,000 copies have been distributed singly and in bulk, with requests ranging all the way from the student to the teacher.

Here is the title cover for leaflets receiving wide distribution in Wisconsin and concerning such ailments as locomotor ataxia, pulmonary tuberculosis, adenoids, kidney trouble, high blood pressure, heart trouble, and countless other topics.

Pseudo-newspapers are also distributed, and in a recent issue of a daily newspaper in Wisconsin appeared a full-page advertisement of a chiropractic institution in Colorado. Incidentally, we checked the advertising rates of the newspaper. A full-page ad costs $289.92.

So-called "health information" columns appear in other newspapers, such columns presumably being edited by a local chiropractor. This group has startling TV programs, and in many other ways is endeavoring to promote its reaches to the entirety of the medical field. In Connecticut, the group successfully steered through the legislature legislation (vetoed by the governor) to permit the use of drugs as taught in chiropractic schools. *Medical Economics,* March, 1956, reports that in Iowa, chiropractors now seek the legal right to call themselves

"physicians," thus permitting them extensive privileges without comparable educational qualifications.

The staff activity? To assemble as much detail as possible, for the purpose of studying the impact upon health conditions in Wisconsin, and in order to offer recommendations to the legislature intended to curb their activities until demonstrated education is available.

THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Blue Shield symbol is familiar to all Wisconsin physicians. But what are staff obligations? It's a good question. I have repeatedly observed that Wisconsin is downright fortunate in that its two Blue Shield plans are actually the "doctors' plan." And what is advanced by physicians as good insurance should be directed by their own professional association. Too many states "let George do it." And in some of those states, delegation has been so complete that Blue Shield could be the profession's Frankenstein. Not so in Wisconsin.

And the staff of the Society is assigned many responsibilities. And one illustration perhaps suffices for many of our projects: Wisconsin's old people . . . not employed . . . but living in a good degree of self-respect and out of their planning in past years.

But for those without hospital, medical and surgical insurance? Having reached the distinguished category of being "aged" they are confronted with frailties of the body being actualities and not remote future possibilities. So the staff is asked to study, and therein lies a great opportunity. It is not apropos of this report to suggest what solution seems to be a distinct possibility, nor how the study may be conducted. It's worth much more than a capsule comment. But the project does illustrate that not only does the staff administer what is in effect, but on direction of the Commission on Prepaid Plans it engages in research not unlike that of medical research. And so research qualifications become a requirement of some Society positions.

Section on Medical History

"Dedicated to the Preservation of Our Medical Heritage"

And it is beginning to roll! A visitor to the building sees a "bloodletter" donated to the Section by Dr. Carl D. Neidhold of Appleton. Doctor Neidhold's description of this old-time device and his comment that it was brought to this country by his grandfather in 1860 and has been kept in the family ever since as a sort of "heirloom" prompts interest in others, many of whom are not in the medical profession itself.

Soon the Section hopes to possess an old-time cutter which, together with a foot-warmer, helped an old-time country doctor on his wintry rounds. A Madison accountant donates a mortar and pestle used by his great-grandfather in the late sixties. Display boards and cabinets are used to present these interesting and often fascinating items and one gift leads to another.

Now comes the time when the staff is to present in "jelled" form a proposal for completing the restoration of the famous Fort Crawford Military Hospital at Prairie du Chien. Much of the restoration has been accomplished. Much remains to be done. And the future will see there a permanent monument to medical science and military medicine. The hospital will be operated as a museum in cooperation with the State Historical Society. Staff activity? The responsibility for following leads, organizing the section, developing the projects that physicians suggest. It is one of the more interesting projects in that historical efforts are seldom so time-pressing as getting out an agenda, or getting ready for another meeting of the legislature.

This is Fort Crawford Hospital (restored) at Prairie du Chien. The Section on Medical History is much interested in the future of this historical structure.

Memorandum From Crownhart

Many physicians in the state . . . possibly to their occasional annoyance . . . have received one of these pink memo forms to summarize current legislative developments. It is your secretary's effort in a psychological field. He fondly hopes that when received, you'll recognize it as containing an important message. And there are many of them of current importance.

Once it was Madison . . . then Washington . . . now both. In one it is state legislation and in the other national, but of no less consequence or interest. While much information on Washington legislation is handled through the facilities of the AMA, that organization, like the State Society, is not much stronger than its weakest component or constituent unit.

Did you read (March, *Wisconsin Medical Journal)* of the Council's resolution on H. R. 7225? or is H. R. 7225 a meaningless code? What about commissioning the osteopath in military service . . . extension of the "doctors' draft law" . . . a medical examiners' system in Wisconsin . . . should clinical psychologists receive certification or licensure through some official arm of the state . . .

Legislation isn't politics, it's an opportunity for the citizen to do one of two things . . . exercise his

right to participate in self-government or give that fundamental right away. If he does the first, he participates as a citizen in a democracy. If the latter, he invites regimentation to the Nth degree. Memos from Crownhart are meaningless without corresponding action by the physician. We do our best to inform . . . you must act.

Wisconsin Public Health Council

Earl Thayer serves as the part-time and unpaid executive secretary of this organization which was founded in 1948 and since has been re-organized and incorporated, with the State Medical Society being one of the eight charter members. Several physicians serve on the board of directors as does your state society secretary.

These several pages from a recent descriptive leaflet adequately describe the purposes of the Council and support, I believe, the decision of the Society that the staff actively participate in its affairs.

People throughout Wisconsin have a keen interest in health. Everywhere they are looking for guidance in working out their health problems. They are seeking the numerous paths that lead to successful health projects and improved health in their own homes and communities. They want the feeling of pride and accomplishment in doing for themselves; and at the same time, they seek the stimulation and satisfaction that comes from doing things together.

That is the reason for the Wisconsin Public Health Council, Inc.

Much has been done since it began in May, 1948. There is still much to do.

some objectives

CAREERS IN HEALTH: Relieve personnel needs in the health field by attracting young people to the opportunities in health care.

HEALTH DEPARTMENTS: The establishment of full-time, adequately budgeted, county and multiple-county health departments staffed by professionally qualified personnel.

FLUORIDATION: Promote the fluoridation of public water supplies according to proper dental, medical, engineering, and public health standards.

LOCAL HEALTH COUNCILS: Promote the organization and development of local health councils or health divisions of community councils.

ENVIRONMENTAL SANITATION: Seek to improve family and community practices in the field of environmental sanitation, a first basic requirement for good health.

BETTER NUTRITION: Encourage better nutritional habits, with special emphasis on drinking milk and eating green and yellow vegetables.

SAFETY: [illegible]

Members of the Society, particularly those in official positions, are well aware of the vast scope of their profession's activity. They see its direct results but are not so well aware of its indirect results. March of Medicine . . . the radio program . . . involves endless circulation of programs, script writing, correspondence. The new SMS Foundation is well under way . . . but its administrative responsibilities are many . . . 30 medical students now financing their education through the old Student Loan Fund and now the SMS Foundation . . . Preparation of the Open Panels under the Compensation Act . . . distributed to more than 50,000 concerns under the act, and posted by about ninety to ninety-five per cent of the plants. Management and publication of the *Wisconsin Medical Journal* . . . any of you write its advertisers? It would help if you would mention the Journal.

It would help, too, if you would visit the exhibits at the Auditorium. Chat for a moment, register, and even a word of thanks. It isn't trite to say: *Those who advertise do so where advertisements are read or seen, and remembered.*

WE WILL DO THE ARRANGING AND SOLICITING—IT'S UP TO YOU TO DO THE REST.

MEMBERSHIP REPORT AS OF DECEMBER 31, 1955

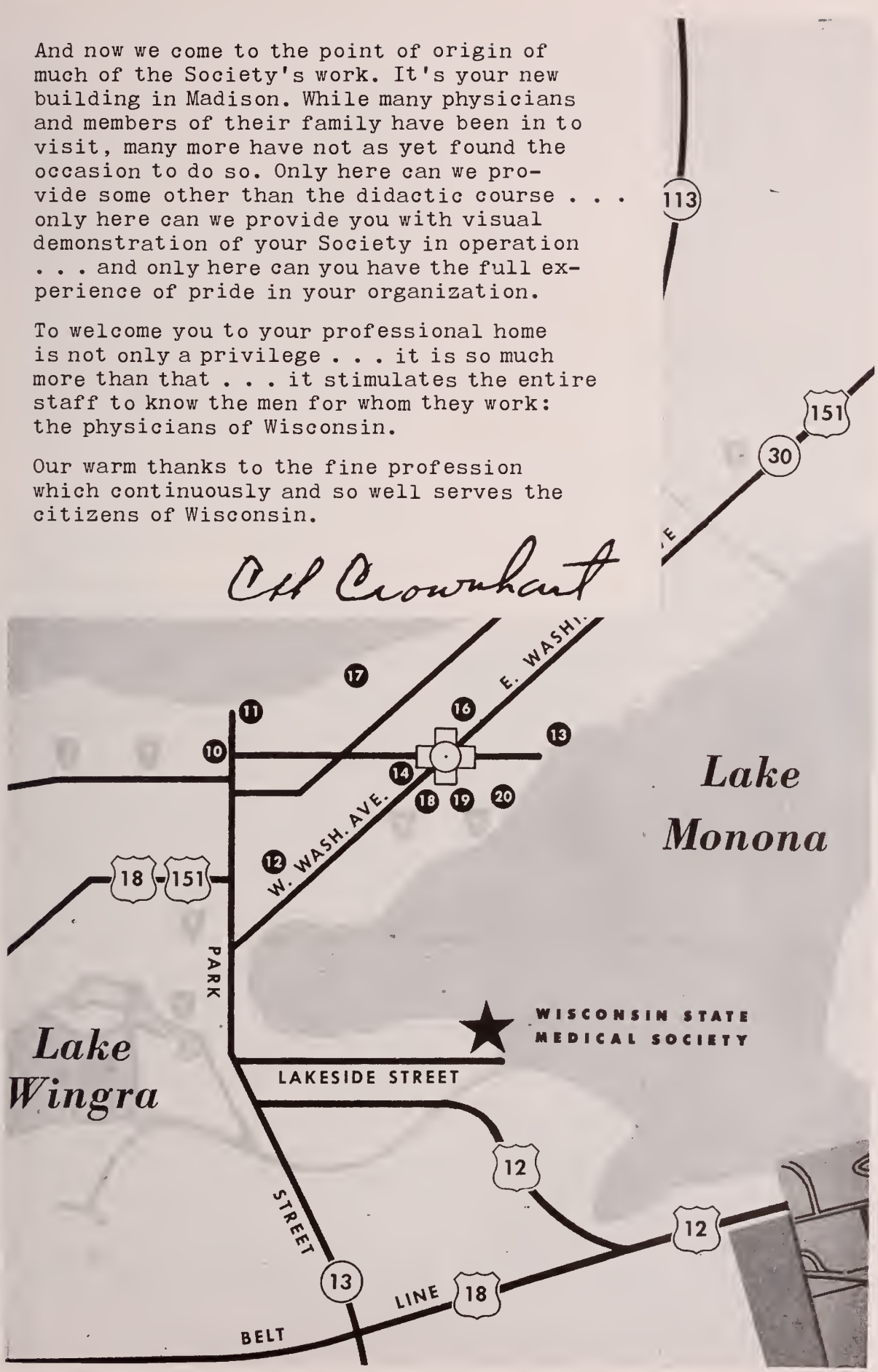
Members paying no dues		178
Affiliate members	55	
Military service members	58	
Honorary members	4	
Life members	61	
Total	178	
Members paying pro rata dues (military service)		31
Associate members ($10 dues)		47
Members in residency training ($3 dues)		160
Members paying $60 dues		2805
Educational Members ($45 dues)		2
Total Membership		3223

And now we come to the point of origin of much of the Society's work. It's your new building in Madison. While many physicians and members of their family have been in to visit, many more have not as yet found the occasion to do so. Only here can we provide some other than the didactic course . . . only here can we provide you with visual demonstration of your Society in operation . . . and only here can you have the full experience of pride in your organization.

To welcome you to your professional home is not only a privilege . . . it is so much more than that . . . it stimulates the entire staff to know the men for whom they work: the physicians of Wisconsin.

Our warm thanks to the fine profession which continuously and so well serves the citizens of Wisconsin.

Ed Crownhart



Supplementary Necrology Report

Secretary Crownhart reported that, since the listing of deceased physicians was published in the *Annual Report for Delegates*, the following physicians had passed away:

J. P. Harkins, Portage
J. E. Gonce, Madison
F. G. Peehn, Sturtevant
D. L. Dawson, Milwaukee

The House of Delegates rose in silent tribute to these deceased physicians.

REPORTS OF STANDING COMMITTEES

The following reports of standing committees were printed in the *Annual Report for Delegates:*

REPORT OF COMMITTEE ON GRIEVANCES

R. E. Fitzgerald, M.D., Chairman; F. A. Nause, M.D.; H. W. Wirka, M.D.; E. W. Mason, M.D.; E. D. Sorenson, M.D.; C. D. Neidhold, M.D.; C. B. Hatleberg, M.D.; J. L. Moffett, M.D. and F. C. Lane, M.D.

PROLOGUE

"This above all: to thine own self be true. And it must follow, as the night the day, Thou canst not then be false to any man." —*Shakespeare*

TEXT

A Question

"Doctor, I am a visitor from out of state. Medicine that I have been taking has been used up. Here is a copy of my prescription, but because it is from another state, local drug stores will not fill it. I wonder if you would provide me with a prescription for a sufficient amount to carry me over until my return?"

Answer

"Madam, this type of medication is outmoded and antiquated. I haven't prescribed it for years and will not do so now."

A Problem

Our inquirer reported that a tentative diagnosis of carcinoma had been made by her family physician. Because of prior operations of consequence, and because of her natural concern, she consulted another physician in the same area. She told him of the tentative diagnosis, but did not identify the physician concerned. The second physician disagreed, and advised our inquirer to "stay away from quacks." Good advice—but the inquirer applied it to her first physician rather than to quacks as the second physician intended.

A Gordian Knot

School authorities in a Wisconsin community approached the only physician in their town, although other physicians practice in the area. They arranged to have parents sign a request for Salk vaccine, and the physician sent in a requisition, using the names supplied him. When the requisition was filled he announced a public clinic for those pupils.

An improper arrangement under the Wisconsin State Plan, approved by federal authorities, and possibly a violation of the Principles of Medical Ethics.

First concern: the pupils, the parents and the school authorities were in ignorance of legal requirements for a public clinic, but was not public health in this instance of greater concern?

Solution: with cooperation of the State Board of Health, and the county nurse, the clinic was rearranged and developed as a public clinic, with a public health physician providing administration.

Information or Misinformation?

Our inquirer asks if a physician has "the right" to charge for refills for a "nerve medicine." All she did was to call the physician (sometimes she had to leave a message because he was out; he would then call her back) and finding out her request, the physician would call the druggist and order another refill. Was it right that the physician make a nominal charge? Did the druggist properly advise her that the physician could leave a permanent order for refills?

So it goes . . .

"My relative in Wisconsin is using medication for asthma prescribed by a physician in the town where she formerly lived. This is inconvenient to obtain and the local doctors don't know what it is. Can anything be done?"

. . . **"Yes, Mrs. Inquirer, we contacted the physician, who replied that he would be glad to furnish the local physicians with the prescription and how it was compounded, and had told you to have them write direct. You apparently forgot his advice to you."**

And another:

"Can a physician charge his full delivery fee if he didn't get to the hospital until too late to be present at actual delivery"?

Under direction of the Society office, a field representative visited the physician. It was true . . . the patient had called the physician, he had called the hospital . . . then he called the anesthetist, instructing no anesthesia because of asthma . . . then he left for the hospital, but the patient had a rapid delivery and his arrival was in time to deliver the placenta, etc.

Then the inquirer was interviewed.

The field representative reports: "She was surprised . . . said her letter had been prompted by friends, and she certainly wasn't going to complain about her care because it had been excellent."

File closed.

EPILOGUE

"Wisconsin's population is nearly three and a half million persons, with more than 2,800 physicians in private practice. The total yearly contact between

physician and patient must be counted in the millions. In the physician's daily contact with the sick he is necessarily confronted with emotional stress and deep personal concern—the perfect culture in which to breed possible misunderstanding and dissatisfaction . . .

". . . if the medical profession exercises its full responsibility, it must be to assist in conveying to the . . . practitioner, as best it can, the importance of knowing what constitutes the art of medical practice." (Report of the Committee on Grievances, 1953)

The condensation of Grievance Committee activities since its last report to the House of Delegates can but suggest the complex scope of its activities. Field trips in the last half of 1955 involved more than 20,000 miles and 150 days of interviews and reports by the staff. The cost of responsibilities carried on under direction of this Committee will total at least $12,000 in 1956, perhaps more. Obviously, most inquiries are confidential, and detailed reporting has not been attempted for these various reasons. Such cases as do appear in the foregoing are illustrative only.

EDUCATION BY THE CARLOAD

A REPORT OF THE COUNCIL ON SCIENTIFIC WORK

S. A. Morton, M.D., Chairman; M. G. Rice, M.D.; L. G. Kindschi, M.D.; K. E. Lemmer, M.D.; M. F. Huth, M. D.; R. S. Baldwin, M.D., ex officio; J. S. Hirschboeck, M.D., ex officio; John Z. Bowers, M.D., ex officio.

The itinerant preacher of yesteryear has found a modern counterpart in medical postgraduate education. The major difference is the substitution of the automobile for the horse and buggy.

Last September, four teaching physicians loaded charts, slide projectors and personal luggage into a car in Madison and started off on a tour that took them to Fond du Lac, Wausau and Portage. In each city, they presented a four-hour instruction program designed primarily for general practitioners: fundamental surgery, obstetrics and gynecology, internal medicine and pediatrics. Four days later, they arrived home travel worn but satisfied with having made personal teaching contact with 151 physicians.

They demonstrate the concept of the Council on Scientific Work that postgraduate education can literally be delivered by the carload almost to the doctor's doorstep.

Attendance was generally good, but the Council believes there is need to impress Society members, and particularly the general practitioners, with the unique values of this program. With a minimum of time away from practice, the physician can review the basic fields of medicine and find considerable that is new. Moreover, if he is a member of the Wisconsin Academy of General Practice, he can earn Category I (Formal) teaching credit without costly travel.

In planning and presenting the 1956 Annual Meeting of the State Medical Society, the Council is deeply appreciative of the unusual cooperation of the specialty groups and the Wisconsin Academy of General Practice. It is hoped that the program, prepared so efficiently under the direction of M. G. Rice, M.D., Stevens Point, will prove to be satisfying to those in attendance. The attempt to produce both variety and caliber in the Annual Meeting program appears to be notably successful, with a general practice day followed by two days which include a wide variety of specialty meetings open to the entire membership.

Looking ahead, the Council believes that there is need for a more general review of all postgraduate educational efforts of both voluntary and professional organizations in Wisconsin so that there is not unnecessary duplication or wasted effort. The Council recommends an early joint effort on the part of the State Medical Society, the two university medical schools, and the allied specialty and voluntary organizations to thoroughly review existing programs and develop a closer coordination between the efforts of all in presenting physician postgraduate programs in the years to come.

MEDICINE TAKES ITS CASE TO THE PEOPLE

A REPORT OF THE COUNCIL ON MEDICAL SERVICE

J. S. Devitt, M.D., Chairman; D. E. Dorchester, M.D.; R. L. MacCornack, M.D.; D. M. Willison, M.D.; W. J. Fencil, M.D.; T. D. Elbe, M.D.; D. N. Goldstein, M.D.; J. F. Maser, M.D. and H. J. Kief, M.D.

COMMITTEE ON NURSING EDUCATION

J. S. Devitt, M.D., Chairman; G. S. Custer, Jr., M.D.; A. H. Heidner, M.D.; G. B Merline, M.D.; R. C. Parkin, M.D.; J. D. Schroeder, M.D.; W. J. Tucker, M.D.; J. H Wishart, M.D. and Mrs Victor S. Falk, Jr.

COMMITTEE ON INDUSTRIAL HEALTH

Elston Belknap, M.D., Chairman; Thomas Burdon, M.D.; D. E. Dorchester, M.D.; David Goldstein, M.D.; G. P. Gredler, M.D.; J. V. Flannery, M.D.; Gordon Petersen, M.D.; Donald Ruch, M.D.; J. M. Wilkie, M.D. and R. S. Wright, M.D.

Pick up an official Wisconsin highway map. You will see a list of towns with general hospitals and some advice on what to do in case of accident.

Turn to page 60 of the Wisconsin AAA Vacation Guide. You will read three pages of first aid suggestions and what to do if you need a physician.

Good advice that will be seen by hundreds of thousands of people each year; advice prepared by the Council on Medical Service and the State Board

of Health in cooperation with the State Highway Department and the Automobile Association.

The Council hopes these efforts help more people to know proper first aid, perhaps saving their own lives and certainly making the doctor's job easier in event of injury.

On behalf of the profession, the Council is taking medicine's case for better health to the people via mass communication:

The radio program, "The March of Medicine," now is broadcast on 41 stations, reaching an estimated 400,000 persons weekly. Nearly 5,000 letters are received each year from listeners—many wanting health advice. They are referred to their own family physicians.

Television stations have responded eagerly to the Society's 13-program series of health kinescopes. The series is shown only with the approval of the medical society in the county where the TV station is located.

News releases go out periodically to announce Society policies and projects, publicize Wisconsin Medical Journal studies, and urge public support of approved health programs.

A weekly health column is prepared for the Wisconsin Agriculturist and Farmer, read in 90 per cent of Wisconsin farm homes.

One hundred thirty businesses and industries receive the Society's "Health News" released monthly for use in their house organs or plant bulletin boards.

Seventy-two radio stations receive the monthly "Spot Announcements" on health.

Thirty-eight 4-H clubs received the Society's award of "Today's Health" subscriptions for achievement in health education. The Council assists in planning the State 4-H Health Program annually.

Service rather than information is another area of the Council activity:

★ **The Wisconsin Medical Journal is now being sent to all senior medical students in both medical schools on a complimentary basis.**

★ **A Senior Medical Student Day will be held this spring at each medical school. Students and their wives or friends will meet with Council members and their wives for a program relating to a young physician's start in medical practice.**

★ **The Placement Service continues its effective work in finding suitable locations for physicians and assisting communities which need doctors. Currently this service lists openings for 136 physicians of all types, while 86 GP's and 139 specialists are seeking locations in Wisconsin.**

★ **Wisconsin was well represented at the AMA's Annual Congress on Industrial Health in Detroit, January 21–24. The Committee on Industrial Health has revised its "Guide for Physicians and Nurses in Industry" and recommends it to all physicians serving industry in any capacity.**

★ **The Council's Committee on Nursing continues to urge establishment of TPN schools in the less metropolitan areas of the state. It is awaiting with interest the report of the Commission for a State-Wide Plan for Nursing Education of the State Board of Nursing. This is reported due in July.**

This is a capsule report of the Council's activity for the past year. Here, in the same form, are its recommendations for the future:

1. **The media of information in Wisconsin—press, radio and TV—are to be commended for the splendid cooperation in providing time, space and talent for sound health education.**
2. **The Council should explore possibilities for a coordinated Lyceum series with the University of Wisconsin Extension Division to bring outstanding health education programs to all Wisconsin high school students. This plan would require Society assistance in developing program format, exhibits and demonstrations. Personnel and operating costs would be assumed by the Extension Division.**
3. **A special effort should be undertaken to develop a closer coordination of public relations programming between state and county medical societies, and a public relations conference for county medical societies should be planned for late 1956 or early 1957 to begin this task.**

"QUACKS" ARE FOR THE DUCKS*

A REPORT OF THE COMMITTEE ON CANCER

J. E. Conley, M.D., Chairman; R. P. Welbourne, M.D.; A. R. Curreri, M.D.; A. C. Taylor, M.D.; P. B. Blanchard, M.D.; R. B. Larsen, M.D.; W. S. Bump, M.D.; G. I. Uhrich, M.D.; J. W. Conklin, M.D.; Ralph C. Frank, M.D.; R. J. Schacht, M.D.; Conrad W. Giesen, M.D. and R. C. Cantwell, M.D.

The physician shook his head. "Mr. Doe, you have asked for the facts. I cannot cure your cancer. We have used all of the approved methods of treatment —x-ray, radium and surgery. Now I can only assure you that we will do everything possible to relieve you."

A few weeks later, the local news columns reported Mr. Doe heading South to a "clinic" where

* Title of a pamphlet issued by the Wisconsin Division, American Cancer Society.

they had the "answer to cancer." A few more weeks and Mr. Doe was back in town. His story was typical:

> **"First, I had to pay $500 down. Then I was put to bed. Sure, I felt good. I was relaxing and eating good. But soon I discovered that everyone in the 'clinic' with me was getting the same 'medicine,' even though we had different kinds of cancer. So I got out, sad but wiser."**

Mr. Doe died of cancer. His father is now a staunch worker for the local cancer society. But it was a hard way to learn that "quacks are for the ducks, not for the person with cancer."

Every physician winces, even rebels, as he sees these returnees from the desperation camp or reads of their attempts to be cured. Can he merely shrug and say, "I told you so?" Can he simply laugh off the full-page ads and throw-away literature that tempt the cancer patient? Can he shut his eyes to cancer quackery operating in some cases within the statutes and in others entirely outside the law?

The Committee on Cancer thinks not. Physicians know the truth: There is no one simple answer for cancer, and physicians have a clear obligation to tell their patients about the dangers of those who do promise cure.

To assist physicians in this task, the Committee has distributed quantities of an outstanding pamphlet for laymen on cancer quackery. Physicians are urged to use it widely among all their patients.

This is but a short step in the right direction. The Committee also recommends that county cancer committees and interested physicians be made an active part of the State Medical Society's broad study on chiropractic and quackery and that early efforts be made to assist physicians and laymen in their understanding of new and unusual claims for the cure or relief of this disease.

In addition, the Committee recommends that:

1. **County societies utilize the services of the Wisconsin Division of the American Cancer Society for a program on "Forty Ways to Reach 80 Without Cancer." This is a review of current diagnostic and treatment procedures in cancer presented in a uniquely interesting fashion by Robert Samp, M.D., assistant to the Director, Tumor Clinic, University of Wisconsin.**

2. **The Wisconsin Division and Milwaukee Division of the American Cancer Society be commended for their encouragement and financial support of basic research at McArdle Institute at the University of Wisconsin and the Tumor Clinic at Marquette University.**

3. **Physicians give increased attention to the psychological care of patients in whom cancer has been diagnosed and especially those in terminal stages.**

REPORT OF THE COMMITTEE ON HOSPITAL RELATIONS

W. B. Hildebrand, M.D., Chairman; A. H. Barr, M.D.; S. R. Beatty, M.D.; O. V. Overton, M.D.; W. C. Henske, M.D.; and S. W. Hollenbeck, M.D.

The following report was distributed to delegates in mimeographed form:

This committee was created in 1950 as a means of implementing the Hess Report adopted by the House of Delegates of the American Medical Association earlier the same year. While the Hess Report was developed primarily to provide a means of appeal for hospital-radiologist-anesthesiologist-pathologist controversies, the Committee on Hospital Relations in Wisconsin was given a more broad authorization.

Your committee has not reported to the House since 1953, nor has a local problem been appealed to it. However, the committee met on April 14, 1956, to review several matters of concern in the area of hospital relations and to review staff assistance which has been provided at the request of local medical groups. Three situations were discussed at the April 14 meeting which might serve to illustrate the general problem:

One—A hospital medical staff asked for advice in the settlement of a dispute between a radiologist and the hospital administrator. In a 10-day period allowed by hospital administration, the staff participated in numerous long distance telephone conversations and attended several conferences with the parties involved.

Two—A hospital board chairman and an administrator sought to establish and enforce all staff rules and regulations. The medical staff, the Councilor for the district, and the local medical society requested Society assistance in developing adequate by-laws for the hospital. This aid was provided; and as a result of certain changes in hospital personnel and the new by-laws, the situation appears to have been materially improved.

Three—A local medical staff and the Councilor for the district requested Society assistance in a situation involving inadequate hospital administration and the development of appropriate by-laws where none existed. Many hours of conferences and travel were contributed to this problem in a very short period of time, and the matter appears on the road to settlement.

In light of these and similar problems, the committee believes that the House of Delegates should be aware of a resolution prepared by the Council on Medical Service and adopted by the general Council on February 26, 1956. This resolution follows:

"WHEREAS, both the physician and the hospital are essential components of the health resources of society, and

"WHEREAS, the respective responsibilities and prerogatives of the physician and the hospital are not only accepted by tradition but are in some respects defined by law, and

"WHEREAS, there has been increasing evidence of tendencies to exceed the accepted and established spheres of activity and to usurp essential prerogatives, and

"WHEREAS, it is the firm conviction of the Council on Medical Service that such tendencies are not in the best interests of either the public or the medical profession; now, therefore, be it

"*Resolved*, That the Council on Medical Service request the general Council of the State Medical Society of Wisconsin to take cognizance of this trend and authorize the Council on Medical Service to establish an *ad hoc* committee to investigate the general and individual relationships between hospitals and physicians and determine if the convictions of the Council on Medical Service on this matter have foundation in fact, and if so recommend appropriate action by the Medical Society."

The Council on Medical Service and this committee are prepared jointly to implement the study approved by the general Council. The purpose of this report is solely to call attention to the problem, the urgent necessity for immediate study, and the need for the development of a long-range program to cope with hospital-physician relations problems.

Your committee recommends that the House of Delegates urge the immediate implementation of the above resolution and that both the Council on Medical Service and the Committee on Hospital Relations, along with any other appropriate committees of the Society, participate in this study and be prepared to present a detailed report no later than the next annual session of the House of Delegates.

Address of the President of the Woman's Auxiliary

Mrs. John J. Boersma, Green Bay: I appreciate the privilege of bringing you a resumé of the past year's activities of the Woman's Auxiliary to the State Medical Society of Wisconsin, and to bring greetings from our 1,606 members. In comparison to the 52 organized county medical societies in the state, we have 34 organized auxiliaries, and had the privilege of helping to organize two new auxiliaries this past year.

Organization is a point of emphasis in the Auxiliary. We need the helping hand and spirit of enthusiasm from new members. We need your help to attain it. The national program theme is "Active Leadership in Community Health." We in Wisconsin cooperate wholeheartedly with this program. As individuals we all assist in community health and philanthropic projects—health drives, church work, hospital auxiliaries, the regional Red Cross blood bank—and a substantial gain in participation has been shown in the mental health program.

Our Nurse Recruitment Program is perhaps our strongest project. Your wives have established a Nurse Scholarship Program amounting to approximately $4,500, which has been awarded to deserving girls who have chosen nursing as their career.

The Nurse Recruitment Program Committee, with the assistance of the Milwaukee County Auxiliary, just had the second successful Future Nurse Club convention on April 21. In just two years, 23 Future Nurse Clubs have been organized in the high schools throughout the state. Your wives are reaching approximately 1,000 high school juniors and seniors, aiding them in preparing themselves for an education in nursing.

Because we know the educational and public relations value of *Today's Health* magazine, we aim to place it in our homes and in the reception rooms of all the doctors and dentists; we seek your cooperation in doing so. Some auxiliaries have given gift subscriptions to hospitals, sanatoria, libraries, and industrial plants.

Contributing to the American Medical Education Foundation is a growing project of interest. It was hoped that every auxiliary would be a contributor this year, regardless of the amount given. Through benefit dances and fund-raising projects, the auxiliary will make a contribution of more than $1,600 in 1956.

During the past year I have attended 16 county meetings, the national AMA Auxiliary conventions in Atlantic City and in Chicago, and the regional AMA Legislative Committee Conference; and I have participated in the panel on legislation at the Auxiliary Conference for State Presidents and Presidents-elect. But one of the outstanding experiences I have had in my year as president has been that of participation in the historic occasion of dedicating the State Medical Society building in Madison last October. Thank you for inviting me.

Through my visits to the county auxiliaries I could not help but notice how popular joint meetings of the county medical society and the auxiliary have become. In one county it was said, "The doctors have a much better attendance at their meetings now that the wives meet on the same night." I'm all for it. The more time I can spend with my husband, the better I like it.

Next to my family, the Medical Society Auxiliary is the most important interest in my life. Its aims represent something wonderful and worth while to me.

In closing, I would like to recall what Sakini, the native character in the play, "Teahouse of the August Moon," said: "Pain makes you think. Thought makes you wise. Wisdom makes life endurable."

May the partnership of the Medical Society and the Auxiliary continue to flourish for many years.

Speaker Fons introduced Mrs. Robert Flanders of Manchester, New Hampshire, president of the Woman's Auxiliary to the American Medical Association, and Mrs. H. W. Christensen of Wausau, president-elect of the Woman's Auxiliary to the State Medical Society of Wisconsin.

Supplementary Report of the Council on Scientific Work

Dr. S. A. Morton, chairman of the Council on Scientific Work, presented the following address:

It is both a privilege and a pleasure to appear before you as the retiring chairman of the Council on Scientific Work. I want to draw to your attention certain problems that have arisen in the field of activity of this committee which should be the concern of all of us.

You know from your own personal experience of the demands made upon the individual physician apart from the actual demands of his practice. There is a diversity of interest among our members; loyalties are developed to our special group, whether we be surgeons, internists, or general practitioners. With more organization of hospital staffs with departmental meetings, the hospital is assuming an increasing role in the dispensing of scientific knowledge.

These are things that have occurred in the evolution of medicine, and we can do little about them. We must accept them, and as a State Society we must change to some extent with the times. However, I feel—and I feel very strongly—that no matter how important the other activities of this Society may be, our most important activity is the advancement of the scientific knowledge of our members.

The Council on Scientific Work is the committee of this Society that is charged with this particular responsibility, furthering the scientific knowledge and training of our members. Our circuit teaching is part of our program. This past year, four groups of four physicians, well known in their fields, accompanied by a moderator (usually Doctor Parkin or Doctor Collentine) and a State Society staff member as chief properties man went to various parts of the state and presented four-hour instruction courses designed primarily for the general practitioner in the smaller communities. Like the itinerant preacher of yesteryear, these men carried their message almost to the doorstep of many of the doctors of the state. We did not strive for big meetings, but we tried to place these groups in areas where we felt they would have an appreciative audience.

The Council believes that you as delegates should impress upon the members of your local societies the unique values of this program. With a minimum of time away from his practice, the physician can have the recent advances in medicine brought to him by leaders in the various fields. Attendance at these programs gave Category I teaching credit to members of the Wisconsin Academy of General Practice.

Our Annual Meeting has presented many problems. This year, under the leadership of Dr. Maurice Rice of Stevens Point, we have tried to develop a program presenting a combination of topics which we sincerely trust will interest the general practitioners and also the members of the various specialty groups within our state organizations. We sincerely hope that our efforts in preparing this program will be rewarded by your active attendance and interest.

Heretofore the preparations for the scientific program of the Annual Meeting and the arrangement of the circuit programs have been about the sum total of the official scientific efforts of this Society. We do not feel that this is enough—not nearly enough.

At the present time there is a lot of postgraduate teaching going on in the state. Our two great medical schools, Marquette and the University of Wisconsin, have postgraduate programs. The Milwaukee County Hospital, the various Veterans Administration hospitals, the various specialty groups, county medical societies, the Academy of General Practice, and some of the private hospitals all are carrying on postgraduate teaching; but there is little or no collaboration between their various teaching units.

Our annual meetings and teaching programs have not changed substantially over the past few years. Are they in tune with the times, or should other teaching methods be employed?

Looking over the lists of those who attended these various meetings, one is impressed by the fact that there is a repetition of the same people at the various meetings. They go to the annual meetings, they go to the postgraduate meetings; but what of the large group of doctors in the state who don't go to the meetings? How can we reach them? They need help, and their patients would benefit from their increased knowledge if we could get our message to them.

The Wisconsin Academy of General Practice is doing a splendid job of encouraging postgraduate education among its members, but there are many of the general practitioners in this state who do not belong to that organization.

Recently there was held in Milwaukee a meeting of representatives of the two medical schools of our state with members of the State Society, to review all the postgraduate educational efforts in our state and to see whether they can be improved. Certain suggestions came out of that meeting.

Recommendation

As chairman of the Council on Scientific Work of this Society, I would like to make a recommendation to you, with the suggestion that you ask the Council of this Society to implement it as far as possible. The recommendation is that the State Medical Society of Wisconsin act as the directing and correlating body for all the medical postgraduate work that is carried on in this state.

In order to do that, certain things should be done:

First: The Council on Scientific Work must increase its activities. It must become a more important committee and not just confine its work to the preparation of the Annual Meeting and of the circuit program.

Second: Certain people should be added to that committee either in official or ex officio positions. These should be the directors of postgraduate education at our two medical schools; the chairman of the Postgraduate Committee of the Wisconsin Academy of General Practice; the person in charge of postgraduate work at the Milwaukee County Hospital; or anyone else who can contribute to the development of a coordinated state program of postgraduate medical education.

Third: To carry out this plan, additional help will have to be provided from the office of the State Medical Society of Wisconsin. At the present time it keeps one staff member and his secretary busy providing for the Annual Meeting and the circuit programs. Only one who has actually worked in this field knows of the endless detail that is required to arrange these meetings and to promote these activities.

Fourth: New techniques of presentation should be explored. There are fine hospitals well distributed throughout the state. The proposition that the postgraduate teaching should be centered around these institutions should be investigated.

Fifth: A re-evaluation of the county medical society programs is in order. As problems of a medical-economic nature have increased, the county societies outside of organized areas have become increasingly absorbed in matters of poor-relief fee schedules, policies in reference to state-supported health programs, and special demands of cooperation by lay groups interested in health matters. The former isolation from medical centers has disappeared with the development of the automobile and good roads, and it may well be that scientific efforts of the smaller county medical society might be combined in group meetings with other societies.

Sixth: An effort should be made to correlate the work of the various groups devoted to the study of a special group of diseases, such as the Wisconsin Heart Association, the Wisconsin Cancer Society, and so on. These groups are anxious to spend money on scientific education and would welcome the opportunity of having this work correlated with the other postgraduate work going on in the state.

This matter is one about which those of us on the Council on Scientific Work feel very strongly. We know that we have lots of teaching ability and material here in the state, and we feel that the State Medical Society of Wisconsin should take the responsibility of bringing that knowledge to its members so that we may better care for our patients, the citizens of Wisconsin.

Supplementary Report of the Division on Maternal and Child Welfare

Dr. T. A. Leonard, Madison, presented the following supplementary report relating to the Maternal Mortality Study: Appearing before you today has as its purpose the matter of presenting a brief summary of the work of the Maternal Mortality Study Committee over the past few years. Any project of this kind must find its only justification in the results which come about through its efforts. These results have been a source of gratification to the committee, and we wish to continue our work in order to banish the last vestige of preventable danger to the expectant mother; as you will see from the statistical evidence, there still are some dangers.

To briefly summarize the work which has gone into this effort so far, we would like to offer the following:

After much study of the organization and the mechanics of other study committees, our committee devised a plan and method which we feel has been adequate to obtain the material needed for the study of each maternal death and to arrive at a fairly adequate evaluation of each case.

The organization of our plan has received attention of the National Committee on Maternal Welfare, and there have been many requests sent to us asking for resumés of our plan for use in their particular state organizations. We feel that at the present time we have eliminated most of the objections which were associated with our early efforts.

Beginning with the first year of study, the results were summarized; and this data was published in the State Medical Journal. In addition to this, there were several articles written by various members of the Study Committee on some of the pertinent causes of maternal demise, and these were subsequently published in the Medical Journal. These periodic publications are continuing. The final summary appeared in the March, 1956, issue.

Slides were made summarizing the results of the study, and this material was presented to more than fifty groups within the state and before two national meetings.

In all of this work an effort has been made to bring before those who attended the chief factors concerned with maternal mortality as found by the Study Committee, and to offer ways and means of preventability wherever possible.

An effort has been made to emphasize the dangers of:

Convenience inductions of labor.

Traumatic deliveries and the substitution of Cesarean section for endangering procedures from below.

Version and extraction, as a hazard to the mother, particularly when performed without adequate relaxing types of anesthesia.

Manual dilatation of the cervix. It has been pointed out that this is a procedure hardly, if ever, justified.

Ruptured uteri occurring from forceful stimulation of labor, manual dilatation, and versions and extractions have all been given due emphasis in these discussions; also, more careful observation of the patient during labor and postpartum has been stressed.

The Study Committee has also advocated that, in case of severe postpartum hemorrhage, the physician seek and correct laceration of cervix or vagina and, in cases of ruptured uteri, repair or remove the structure rather than depend on packs or oxytocics as a primary measure. In using these latter measures, valuable time may be lost, which could possibly make the difference between life and death for the mother.

The suspicion, diagnosis, and recognition of the state of defibrinogenization of the blood and means of combating this tragic and frustrating condition have been discussed. It has been pointed out that these conditions are most likely to occur in abruptio placentae, in the patient carrying a dead fetus whether Rh sensitized or not, and that these patients should all be studied from the standpoint of blood clotting mechanism before instituting delivery. The Study Committee has popularized the use of fibrinogen in these cases, and now almost all hospitals have fibrinogen available.

	First 12 months	Second 12 months	Third 12 months
Maternal Deaths	66	62	39
Pure Obstetric Deaths	39	31	23
Reduction in Hemorrhage	22	16	8
Ruptured Uteri	15	9	1 Spontaneous in old scar
Version and Extraction	6	4	1
Eclampsia	8	4	8
Embolic Pneumonia	1	9	9
Anesthetic Deaths	3 (Caudal, became total)	2 (1 caudal became total; 1 inhalation of vomitus)	3 (Inhalation of vomitus)
Ectopic Pregnancies—Not Operated	3	2	1
Poliomyelitis	3	3	4
Deaths from Miscellaneous Causes	27	31	16

The eclamptic patient has received emphasis. Earlier hospitalization, better stabilization of the patient prior to section or induction of labor, and longer periods of hospitalization following have been recommended.

The medical complications of pregnancy were given a role of importance, in that the Study Committee has felt that at times better evaluation of the patient as a whole and due consideration for the medical entities which often accompany pregnancy can and should be factors in the saving of some lives, for as the pure obstetrical deaths decrease, the medical complications of pregnancy are going to assume a role of greater importance.

It has been pointed out that antibiotics and chemotherapy are no substitutes for good antiseptic techniques.

It has been noted by the Study Committee that in several cases of demise the patient had not sought nor received adequate prenatal care. Much is to be done in education along these lines, for oftentimes the physician has been confronted with factors at the time of delivery which might have been controlled to satisfaction if he had known about them previously.

Consultations were advocated when and wherever necessary. When difficulties arise we should share with each other our knowledge, advice, and help.

Autopsies should be obtained wherever possible so that we all may learn by the actualities rather than from opinion, even though the opinion may oftentimes be correct.

Another point of emphasis—and this is a touchy one—is the conduct, management, and personnel of many obstetric departments. Many times the department is subservient to other departments. The equipment and facilities are poor, and anesthesia services are poor. Hospital administration fails to respond to the plea of staff members to bring these departments up to a par with other services.

Until every department is equipped with all of the facilities and personnel to guarantee all of the factors of safety to every mother in labor, we will not be fulfilling our responsibilities to them. The Study Committee is concerned at present with suggesting to hospitals a resumé of minimal standards for the conduct of a good obstetric department.

Further Recommendations: More intensive efforts during the coming year in giving talks with slides demonstrating the facts above enumerated.

Attempts to improve the hospital facilities and suggested minimal standards for improving of obstetrical departments and practices, through talks before hospital associations.

Elimination of deaths from poliomyelitis by adequate vaccination programs.

It is believed by the Study Committee that the results of this three-year study have fully justified the time, effort, and expenditure of money involved. We hope to continue with the approval of the Council and the House of Delegates.

Report of the Charitable, Educational, and Scientific Foundation Incorporated of the State Medical Society of Wisconsin

Dr. Ervin L. Bernhart, Milwaukee, presented the following report of the first annual meeting of the Board of Trustees of the Charitable, Educational, and Scientific Foundation Incorporated of the State Medical Society, held at noon, Tuesday, May 1, 1956, at the Hotel Schroeder in Milwaukee:

A number of definitive actions were taken. There was an election of officers. I was elected president, Dr. Arthur J. McCarey of Green Bay, vice-president, and Dr. Gordon Schulz of Union Grove, treasurer. The secretary of our Society serves as secretary of the Foundation.

The Board of Trustees authorized creation of the following committees: Executive, Scientific Research, Physician Relations, Loans and Education, and Medical Economics. It has recommended to the Council that there be elected by it some nonmedical trustees who can assist in its various projects.

I can report to you that two business organizations have indicated interest in contributing to scientific research in inhalation therapy and in hearing loss due to industrial occupation. Blue Shield of Wisconsin has contributed $5,000 from investment income to assist in financing a study relative to the extension of voluntary insurance to those who now fall within the definition of "aged."

The Trustees authorized a project to undertake restoration of the military hospital at Fort Crawford, to be operated in conjunction with the State Historical Society as a museum of medical and military medical history.

A report with reference to this meeting will be distributed to all physicians in the state as soon as possible.

The Trustees recommend to the House of Delegates that each active member of the State Medical Society of Wisconsin be invited to contribute, on a voluntary basis, the sum of $10 to the Foundation for the fiscal year beginning July 1, 1956.

Again I emphasize that this is a brief summary of transactions today, but as a matter of personal opinion I wish to emphasize also that this Foundation is already beginning to demonstrate its practical value to the public health of Wisconsin and to the medical profession.

Report of the State Advisory Committee on Poliomyelitis Vaccine by Doctor Salk

Dr. W. B. Hildebrand, Menasha, chairman of the Advisory Committee, presented the following report:

Following the announcement of the unsuccessful field trials conducted by the National Foundation for Infantile Paralysis in the field of vaccination against the disease in 1954, the President of the United States called a conference of leaders in the public health field, virologists, educators, doctors of medicine, and prominent laymen throughout the country to discuss the best methods of handling a very difficult situation. It was quite obvious that until the supplies of vaccine met the demand, inasmuch as the results of the field trials indicated that the vaccine was clearly effective against paralytic poliomyelitis, planning of an effective nature had to be developed.

At the conference held in Washington, it was suggested that the several states appoint subcommittees to advise both the medical profession and the state legislatures, as well as the citizens of the several states, on developments and on the best method of proceeding in order that there be a minimum of confusion and misunderstanding as far as the vaccination program was concerned.

On April 26, 1955, the following committee was appointed to include broad representation from the various strata of our economic, legislative, and professional lives in Wisconsin.

W. B. Hildebrand, M.D., Menasha (Chairman)
Carl N. Neupert, M.D., Madison (Secretary)
E. L. Bernhardt, M.D., West Bend
T. W. Tormey, Jr., M.D., Madison
L. O. Simenstad, M.D., Osceola
Arthur J. McCarey, M.D., Green Bay
Mr. Arthur Wegner, Madison
Mr. Sylvester E. Dretzka, Milwaukee
Mr. George E. Watson, Madison
Honorable Arnold Cane, Menasha
Miss Adele Stahl, R.N., Madison
Mr. Frank Strapp, Madison
F. J. Mellencamp, M.D., Milwaukee
Milton Feig, M.D., Madison
Mr. Wilbur Schmidt, Madison

The first meeting of the committee was held on May 2, 1955, in connection with the Annual Meeting of the Wisconsin State Medical Society in Milwaukee. At that time, the committee formed some broad concepts as to its duties and responsibilities. Its responsibilities were thought to be as follows:

1. To recommend to the members of the medical profession, to the government, and to the citizens of the State of Wisconsin what procedures, in connection with the administration of the vaccine, seemed the best at any given time in the light of current information available, so that an orderly program could be effected.

2. To cooperate with the several manufacturers and the U. S. Public Health Service in utilizing what vaccine became available at any given time, in the age brackets to be designated by the U. S. Public Health Service.

3. To protect our citizens against black market operations in the vaccine, and, in so far as possible, to protect them against unsafe procedures in connection with the use and administration of the vaccine, and to carry out the order of President Eisenhower; namely, that no child should be deprived of the protection that the vaccine affords because of his inability to pay for it.

4. To set up an orderly, equitable, fair plan of distribution of the vaccine to commercial outlets and to the doctors of Wisconsin as the vaccine became available.

All of the decisions made by the committee, as well as its recommendations, have been predicated on the previously listed philosophical, economic, and ethical concepts. These recommendations were made at the meeting on May 2, 1955:

1. That the distribution of current available supplies be limited to the age bracket laid down by the U. S. Public Health Service in so far as the vaccine becomes available.

2. That as the vaccine becomes available, due notices should be given to the citizens and the medical profession and the priority extended to include children above and below such bracket as is designated at any time.

3. That, because all polio vaccine coming into Wisconsin is certified as to safety, potency, and purity by the Biologics Control Laboratory of the National Institutes of Health prior to its release, the committee recommends that such vaccine be put to use as rapidly as available, without delay by the imposition of additional requirements as to safety, potency, and purity.

4. That, to assure that the vaccine is being administered to those entitled to it under the priority arrangement and to assure that only the vaccine manufactured by licensed establishments is actually provided, the vaccine should be released only to licensed physicians through the normal commercial distribution channels.

5. That reassurance should be given the public that, should appropriations by various localities of special funds with which to provide local citizens with free vaccine be allotted, such funds will not affect the equitable distribution according to the various age priorities.

6. That the schools throughout the State of Wisconsin distribute educational information prepared by the State Medical Society of Wisconsin for the parents of all pupils in elementary schools on the problems of supply, distribution, and administration of the vaccine.

7. That after the vaccine has been used from the containers in which it is shipped, destruction of the containers should be carried out as rapidly as possible in order to avoid their refill for black market purposes.

At subsequent meetings of the committee, the following recommendations were made and business transacted:

It was anticipated that some problem concerning the distribution of the vaccine to wards of the state

or county, children in institutions and foster homes, and those receiving public assistance in the State of Wisconsin would arise. The numbers in the priority groups totaled 44,355. It must be remembered, however, that 2,655 of the first- and second-grade youngsters had been covered by the National Foundation for Infantile Paralysis Program in the spring of 1955, prior to the time that school closed. This reduced the total to 41,700. It was decided that 25% of the vaccine coming into the state would be reserved for the use of those children who otherwise would not be able to get it.

In July, 1955, it was decided to go along with the U. S. Public Health Service recommendation that, until the then-present confusion regarding the use of the vaccine and the testing for safety be cleared, no more vaccine would be distributed nor used in the state. This, of course, followed the tragic reports of poliomyelitis being contracted by children in California and Idaho, and some in other states, quite soon after they had been inoculated with vaccine made by certain of the pharmaceutical manufacturers.

Polio Vaccine Bill Passed—Suggestions for Use of Vaccine Made

Early in August, information was received that the Federal Polio Vaccine Bill had passed both houses of Congress, and Wisconsin was allotted $610,539 for vaccine that was to have been obligated by February 14, 1956, and $88,900 to the State Board of Health in its general health grant for the administration of polio vaccine, making special studies, and epidemiological aspects, etc., of the polio problem. The U. S. Public Health Service at that time advised that administration be limited to children between 5 and 9 years of age and that manufacturers were to be advised as to distribution quantities for various states based on age group priorities. Along with the announcement that the federal polio vaccine funds had been made available, suggestions were made by the National Advisory Committee for the suggested principles for intrastate distribution and use of the vaccine as it became available. These suggestions, objectives, and principles were as follows:

a. To assure that vaccine would be made available to all eligible persons in the state.
b. To assure public acceptance of the program.
c. To assure acceptance of and adherence to program principles by physicians, pharmacists, local health officers, and other related professional groups.
d. To assure equitable distribution of vaccine to eligible persons in all areas of the state.
e. To insure the maintenance of records.

The principal problems seem to us to be:

1. That of the possibility of inequitable distribution within the state.
2. The problem of the adherence by physicians to national and state policies of distribution.
3. The difficulties that we might encounter pertaining to vaccine from manufacturers.

The following elements for developing our state plan were finally adopted by the committee:

a. To keep the general public informed of state plans for distribution and use of vaccine.
b. To establish close working relationships with state medical associations, county medical societies, state pharmaceutical associations, and other professional groups and to encourage these organizations to impress their members with the necessity for complying with policies regarding priority groups, the exchange of vaccine among local physicians, and maintenance of records regarding distribution and use of the vaccine.
c. To request that all physicians maintain records of children inoculated, showing such information as the name and age of the person vaccinated, site of vaccination, name of manufacturer, manufacturer's order number and filling number.
d. Advise all persons and organizations concerned of the amount of vaccine available to the state, the amount which may be purchased by public agencies and other purchasers, and the manufacturer from which the vaccine might be obtained.
e. Advise each public agency of the specific quantity of vaccine which may be purchased or require that orders by public agencies be approved by the state before such orders are placed with manufacturers.
f. To allocate the total vaccine available to the state to counties or other geographical areas based on the total population of the priority age group involved.
g. To organize local health units and private physicians to administer vaccine purchased with federal, state, or local funds—should they wish to do so.
h. Develop plans which will insure that persons in designated priority groups who are not vaccinated by their private physicians are vaccinated in public programs.
i. Keep appraised of vaccine shipped into the various areas of the state through copies of invoices or reports provided by each manufacturer.
j. Identify areas of the state receiving vaccine in quantities significantly out of proportion to the total population of the area or the priority group of the area and request the Public Health Service to negotiate with manufacturers to reduce or increase shipments to the area as circumstances may arise.
k. Encourage communities and counties to develop their own plans for distribution and use of the vaccine, including the review and adjustment of orders prior to their placement with manufacturers.

It must be remembered that these were recommendations from the National Advisory Committee and the U. S. Public Health Service to our state advisory committee; and, in so far as they were possible to implement, such was done.

Administration of Funds

A decision had to be made, however, as to how we would administer the funds allotted to us through the grants from the federal government. One of the stipulations made in the legislation passed by both houses was to the effect that some central state agency must be made responsible for purchasing and distributing the vaccine. It was the opinion of

the committee that the State Board of Health would be the logical agency to undertake such a program, gigantic as it seemed to be, due to the fact that they already had sufficient machinery in operation so that it could be added to their duties with a minimum of organizational work. In making a decision it must be remembered that the law provided that in the Polio Vaccination Program no means test or other discrimination based on financial ability of individuals be imposed to limit the eligibility of persons to receive vaccinations against polio. In addition, one of the stipulations was that all polio vaccine purchased with these funds should be used for vaccination of eligible persons pursuant to a plan which must be submitted to the U. S. Public Health Service and Surgeon General setting forth the method or methods by which vaccinations will be made available through public agencies, approved nonprofit organizations, private physicians, or otherwise.

It had been the thought of the committee prior to the passage of the act that the best plan would be to allow the material to come into the state through normal commercial drug channels with the State Board of Health watching each invoice as it came in and determining whether or not equitable distribution was being made. If it did not appear that such distribution was being made, shifts in invoices would then be made so that as much of the state as possible would be covered with existing supplies. As it turned out, however, such supplies were only token ones because of the scarcity of the vaccine. The scarcity of the vaccine and the delay in the expected timetable was, of course, due to the change in testing methods and the increase in the time necessary to make the vaccine. By the time the federal funds became available, very little vaccine had been distributed in the State of Wisconsin. By August 9, only 53,600 cc. had been released through commercial channels.

State Board of Health Named State Purchasing Agent

The committee had the following possible alternatives as far as the use of the federal funds was concerned:

1. We could allow distribution through normal commercial channels as had been started, with the State Board of Health acting as the agency which would determine equitable distribution by watching invoices as they came through the State of Wisconsin.

2. The State Board of Health could be made a single state purchasing agency such as had been recommended by the Surgeon General, and then individual physicians could be allowed to order the vaccine allotted at any particular time by the U. S. Public Health Service for their patients in the age priority group, giving names and ages of patients. The orders would be sent direct to the State Board of Health, from which vaccine would then be sent to the individual physicians as the supplies became available. With this plan, also, was the necessity of setting up some percentage basis by which local municipalities and communities could carry on public vaccination programs of their own, such a program being implied in the law and suggested by the Surgeon General.

The committee adopted the latter plan, which was put into effect and which has been operating to date. It was decided that not more than 10% of the total amount of vaccine coming into the State of Wisconsin would be allotted for use in public clinics; that January 1, 1956, would be made the deadline for ordering by individual physicians on a private basis; and that, after January 1, all those areas where public clinics were to be conducted would receive vaccine sufficient to conduct those clinics on the basis of 10% of the eligible population until the entire clinic need had been satisfied.

It might be well to state here that our state had one of the lowest percentages for amount of total vaccine going to public clinics. The national average was something like 40%, and our neighboring states channeled a much higher percentage of their total vaccine into public clinics than we. There was much criticism of the committee, however, by some of our doctors in the state because we allotted any vaccine for public clinic use.

Distribution of Vaccine

From time to time the committee sent out publicity advising parents and physicians as to the status of the program, how much vaccine was coming into the state, and approximately what the timetable would be as far as the future was concerned. The necessity of keeping accurate records on all patients inoculated with the vaccine was emphasized and re-emphasized to all doctors of the state. It was not until approximately October 1, 1955, that any sizable amount of vaccine came through the purchasing agency in the State of Wisconsin—the State Board of Health. From October 1 through December 31, 1955, the purchasing agency distributed 301,014 cc. of polio vaccine to private physicians. By December 31 of 1955 the Board of Health had accumulated a backlog of unfilled requests for vaccine from private physicians amounting to approximately 195,000 cc. This backlog was reduced as rapidly as possible. It must be remembered, however, that no orders were accepted for vaccine after January 1, 1956. The total backlog plus the total distributed amounted to nearly 500,000 cc., or approximately 2 cc. each for approximately 250,000 children; this number of children included about 23% of all those from 0 to 14 years of age, which priority ages the U. S. Public Health Service had changed to on or about November 1, 1955. The total number of these children plus pregnant women in Wisconsin at the end of the year was 1,074,941.

It must be remembered that approximately 96,000 children had been immunized with vaccine furnished by the National Foundation, and the commercial vaccine distributed should have been sufficient to immunize an additional 40,000. Therefore, adding the three figures—the amount distributed and on order by the State Board of Health, the amount furnished through the National Foundation's program, and the amount of the commercial vaccine distributed before the central state purchasing agency came into operation—would make a total amount that could benefit approximately 386,000 children and pregnant women, about 35% of the eligible group.

At the latest meeting of the full committee held in March, 1956, several very important policy recommendations were considered and adopted. It was

known at that time that Congress was contemplating the appropriation of additional funds in the amount of $33,000,000 for vaccine purchase over and above the previous funds authorized under Public Law 411 of August, 1955. Decision had to be made on whether or not, if we accepted additional funds from the federal government, we would resume the present system of distribution of vaccine to physicians on request as soon as public clinic requests received by March 1 had been met, or if we would modify that procedure by releasing part of the vaccine through commercial channels and part by way of requests through the State Board of Health. It was felt that, in order to insure equitable distribution over the state and in view of the brief experience during last August and September by way of commercial channel distribution, which was quite uneven with some physicians or groups having orders delivered worth $4,000 while others were unable to get any, until the supplies were equal to the demand, we should continue the present system of distribution through the State Board of Health to physicians on request until all available federal funds were exhausted. It was felt this method of distribution results in the most equitable method of utilization. The committee took full cognizance of and agreed with the fact that most physicians were in accord in the state and that there was equitable opportunity under the present system, but that physicians resented the implication of government control. The committee felt likewise but also felt that the public interest could best be served by continuing the present method, at least temporarily.

The following statement was prepared to be sent to the pharmacists in the State of Wisconsin, indicating the position of the committee as to possible future distribution through commercial channels:

"The State Advisory Committee on Poliomyelitis Vaccine has carefully considered the question of commercial distribution of vaccine by sale through normal channels.

"The committee feels that in view of the limited supply allotted to this state, and in the interest of continuing equitable distribution, the present method of purchasing and distributing the vaccine by the State Board of Health should be continued.

"Under normal commercial distribution, the sale of poliomyelitis vaccine can only be distributed equitably on a geographic population basis. This means that individual sales to physicians and pharmacies may and can be such that only a few physicians and a few pharmacies may be able to purchase the bulk of a limited supply. It is felt, because of this danger, that the eligible population can best be reached through purchase of vaccine by the State Board of Health and distribution on proper request to physicians.

"As soon as the supply of vaccine approaches or meets the demand, the State Poliomyelitis Vaccine Committee intends to recommend distribution through normal commercial channels."

Information had been received that throughout the state parents were urgently requesting that vaccine be made available under the plan for third or booster doses for those who had had the first two doses previously, and that the originally recommended interval of seven months between the second and third doses had elapsed or soon would. It was brought out that the third doses could be postponed a year or more without loss of response on the part of the patient, that preliminary studies being made by the Board of Health indicated that two injections of polio vaccine are between 80% and 90% effective in preventing paralytic poliomyelitis and that third or booster doses should be delayed during the period of short supply, and that the most effective use of the vaccine to prevent paralytic polio would be accomplished by limiting usage to two doses. It was felt that using the three-dose method, at present, is relatively less important than giving the first two doses to eligible children who would otherwise not benefit from the resulting high percentage of protection. The committee also decided that a progress report should be made to the physicians in the State of Wisconsin, as well as to the citizens, through the press, giving information on all aspects and phases of the program to date. Such was done through the press and in a letter to all physicians as of March 23, 1956.

Statistics

Charts have been prepared to disclose where we stand on our program. Information is summarized for each county and includes the total cubic centimeters of vaccine to date, including that used in public clinics, delivered to each county; the estimated population of 0 to 14 years and pregnant women in each county; and the per cent of that population furnished 2 cc. of vaccine in each county. The totals are as follows:

Total cc.'s vaccine to date, including amount used in public clinics, distributed to State of Wisconsin—778,402

Estimated population 0 to 14 years and pregnant women in State of Wisconsin—1,074,941

Percentage of the population furnished 2 cc. vaccine in State of Wisconsin—36.2%

Some very interesting statistics appear in the breakdown, showing that the percentage of participation and acceptance of the program very closely approximates the degree of seriousness of poliomyelitis in the county involved. The range of participation runs from 1.9% up to as high as 78.4%. The reason for such public apathy in some of our counties is not known. Certainly, it is not because of unavailability of the vaccine because, as has been explained previously and as is well known to all of the physicians in Wisconsin, each physician has been able to order the vaccine since October 1, 1955, on the basis of the number of his patients falling into the age bracket of 0 to 14 years of age and all his obstetrical patients. The chart previously referred to includes the latest available figures obtained from the purchasing agency, the State Board of Health. It is to be remembered that these figures change daily; and what is true today, of course, is not necessarily true tomorrow.

It should be mentioned that the chart previously referred to does not include that amount of vaccine used in the N.F.I.P. Program a year ago. There was sufficient vaccine used in that program to cover an additional 10% of the eligible children. Therefore, this figure must be added to the total, making a grand total of 46.2% of all children between 0 and

14 and all pregnant women in this state who have received at least two injections of the vaccine.

Current Status of Program

Where do we stand as of today? As of April 26, each physician in the State of Wisconsin received word that he could again begin ordering vaccine for his patients as was done up to January 1 on the basis of the number of those eligible children between 0 and 14 years of age and pregnant women. All of the vaccine requested in the public clinic program has either been shipped out or released and on its way. There were 104 requests for public clinics which are being or will be held in the state. It might be of interest to know that the committee felt that no public clinic should be held without the approval of the county medical society in the area involved. As far as I know, approval was given for clinics in all but two counties of the State of Wisconsin. At least two county societies refused to accept the philosophy of the public clinic. The committee, although feeling that this was poor public relations, went along with its original premise and did not grant clinics in those counties.

Releases of vaccine are being stepped up very rapidly. There is no way, however, of determining when the supply of vaccine will meet the demand. It is anticipated that when the supply line and the demand line cross each other, there will then no longer be public hysteria or demand or newspaper publicity as there has been in the past. It is felt that in the not too far distant future, and certainly prior to the time that the next Annual Meeting of the Wisconsin State Medical Society is held, there will no longer be any need for an advisory committee such as ours. When, in the estimation of the committee, the program is running smoothly in Wisconsin on a normal commercial distribution basis—as is similar with any other immunization procedure—then this committee will dissolve itself and make a final report to the Council of the State Medical Society.

The committee's job has been to lay down broad concepts for action and implementation within the state which it has felt would be in the best public interest. It is unfortunate that some of our physicians have taken the attitude that the vaccine was created for the personal use of the physician and for his benefit and not for the benefit of the patient. The committee is happy, however, to report that these physicians have, by far, been in the minority; and it is the opinion of the committee that the regulations and concepts that have been laid down for the use and distribution of the vaccine have been adhered to largely throughout the state.

No tribute can be paid which would adequately cover how the committee feels about the magnificent cooperation and efficiency of Dr. Carl Neupert and his State Board of Health staff. Through the efficiency of his department and through his insight into the entire problem, he has made our task very easy. All of us—not only the committee, not alone the State Medical Society, but the entire state—owe him a great debt, for he has been the man who has done, by far, the greatest amount of work and who has provided us with the most feasible suggestions and plans to expedite this program.

The chairman of the committee suggests that a letter be sent to the lay members of the committee thanking them for their generous contributions of time and talents in order that the committee might function efficiently. The chairman of the committee would also like at this time to publicly thank the members of his committee and express to the State Medical Society his heartfelt thanks, especially to Mr. Charles Crownhart, Mr. Earl Thayer, and the outgoing president, Dr. E. L. Bernhart, for what they have contributed in the way of help and advice to the committee.

Remarks of the State Health Officer

Dr. Carl N. Neupert: It is not news to you that Wisconsin people are most fortunate in having a high level of health services available to them. The results are measurable. But I will say to you that Wisconsin is blessed with high-type, well-qualified physicians who not only apply their knowledge and skill in the care of the sick, but increasingly apply them to keeping people well, to preventing illnesses as well as restoring to health those who are ill.

Currently there are nearly three times as many births as deaths per year in our state, and you and your colleagues attend nearly all of them, employing your knowledge and skills in assuring safe arrival of the former and in postponement of the latter. Between the alpha and omega you do your best to serve 3½ million individuals, with the assistance of nurses and others. Among the contributing factors to that service is the availability of good hospitals within 30 miles of practically all people over the state, with more and more people being cared for in those hospitals.

All of those phases of health services are extremely important; but without taking anything away, we still recognize that there are also vitally important aspects to the prevention of illness and maintenance of health, commonly referred to as public health, that are essential and that practicing physicians are not in a position to provide.

Control of environmental factors—safe water, sewage disposal, pure food, and so on; the tracking down of sources of spread of communicable diseases; providing certain laboratory services; gathering and maintaining statistical data, including recordings of births, deaths, and the incidence of disease; bringing to people sound health information to influence them to practice sound principles of healthful living and to go to their doctors before they are ill—these aspects are the proper role of the official health agency.

Voluntary health agencies play an important role, and research (to fill in the gaps of what we do not know about the causes and prevention or cure of disease) is carried on for the most part by others than practicing physicians.

All of these groups working together bring the best results. We have been working together pretty well, you and your colleagues and the official health agency I represent. My appearance here today, as in years past, signifies that. There have been some excellent results of that close working relationship that we in the State Board of Health treasure so highly.

For example, from our vantage point as collectors and analyzers of the birth and death certificates you provide, we have been able to point up some

of the preventable hazards of childbirth. Our Doctor Hunter "stayed with" her convictions as to what could be done to prevent certain of the maternal deaths reported until your Committee on Maternal and Child Welfare went into action—and when it did, things began to happen.

The picture was good before, with Wisconsin ranking among the better states in maternal mortality rates; but following the past three years of concentrated effort on your part, we are approaching the ultimate in safe deliveries for mothers in childbirth.

I am sure you would give recognition to the essential stimulation generating from the State Board of Health in years past to get children, especially infants, immunized against diphtheria, smallpox, and whooping cough, resulting in the practical elimination of the first two and effective control of the latter.

We have been almost free of typhoid fever for many years as a result of activity in procuring safe water supplies and foods and the follow-up of typhoid fever carriers. This year we have an unusual incidence (out of the usual summer season for typhoid), with the occurrence of 21 cases since the beginning of the year—more cases in four months than we usually have all year. We are actively working to find the cause with the help of the U. S. Public Health Service and the Food and Drug Administration. This is another example of the need for teamwork between you and our agency.

We have done well together in preventing or controlling communicable diseases. Largely as a result, many deaths have been prevented in our younger age groups so that over the country infants born today can expect to reach age 69, whereas at the turn of the century that expectancy was but 47.

Ours is now an aging population, with the chronic diseases as our principal cause of illness and death. To make further progress, we must concentrate on conquering such chronic diseases as the cardiovascular diseases, cancer, arthritis, and mental illnesses.

As we move into these fields, the official public health phases of the team approach will be much less effective in Wisconsin than in many states. Except for our larger cities, we are not nearly so well covered as are most states with full-time local health departments to provide the individual contact service necessary to bring results.

We can expect rapid developments in the fields of research that are now being so extensively enlarged over what has been possible in the past to fill in much of what we do not know about the causes, nature, and prevention of the chronic diseases. But there is even now a great lag between what is known and the application of that knowledge by people generally. Cancer is still not being found early enough, though there has been progress in our state in the past five years, according to our preliminary study of the reports.

As the fruits of the stepped-up research program become available, we in Wisconsin will be at a relative disadvantage as far as the official public health services of our State Board of Health are concerned because of lack of professional personnel, especially public-health-trained physicians. We thinly cover the state by way of eight district offices, three of which are functioning as best they can without medical directors. Those vacancies have existed for several years, as has that of a director of our Division of Tuberculosis Control.

With fewer physicians to cover increasing loads made more critical by additions such as civil defense and the polio vaccine program, there can be but one prediction as to how we will be able to meet any additional activities such as working on the chronic disease problem. We won't be able to do the job well.

Last December four of us, two representing the State Medical Society and two the State Board of Health, visited the state health departments of two fairly representative states to learn how they were functioning, especially what the reason was for their success in coverage with local health departments, and what they were doing toward meeting the chronic disease problem.

In our day and a half of concentrated conferences with the state commissioners of health and their individual staff members in Virginia and in New York, we learned much. Both states had liberal state and federal aids to meet over half of the total cost of operating local (county) health departments. We have none in Wisconsin.

In both states there was close liaison between the state department and the state medical society and with the medical schools. New York is engaged in two significant research programs, one a state employee cardiovascular disease study, and one a program in a state cancer hospital.

Virginia, with a population equivalent to that of Wisconsin, has a budget for its State Health Department approximately twice that of Wisconsin. New York's was so extensive and comprehensive as to make a comparison impossible. We were green with envy and tremendously impressed with what they are doing.

One more brief comparison. About a week ago an Illinois suburban health officer took us to task before a public meeting in this room for our relatively poor showing in the data on tuberculosis x-ray case finding as recently released by the U. S. Public Health Service. He pointed out that Illinois had reached 20% of its population last year, while we in Wisconsin had reached but 8.2%. Our record of 50,000 miniature x-rays per bus stood up well, but our total program did not match theirs.

During the past several years the State Board of Health has been suffering curtailments budgetwise as a result of reductions in federal funds and by action of the people of the state through their legislature. As taxpayers, you and they have gotten much more than full value for any investments made in preventive public health by way of appropriations to the State Board of Health.

You can't buy some of the devotion-to-duty type of service you have been getting just with money. These people don't look on their service as "just another job." Some of our best people, especially physicians, are becoming discouraged. Personally, if I didn't believe that things would improve, I would be discouraged, too.

For example, consider the venereal disease problem. We in Wisconsin have had one of the best rec-

ords in the country. The incidence rate among our inductees during World War II was the second lowest in the nation. There has been a further decline since, to our low of 1,140 cases reported in 1953. However, in 1954 the number went up to 1,287 and in 1955 to 1,401.

Since we are hampered (except in our larger cities) by a lack of full-time local health departments, the control of venereal diseases as to tracing sources of infection, bringing preventive educational programs to our youngsters, and so on, is largely a central effort by the State Board of Health with the help of local public health nurses. Except for some self-treatment, you physicians treat the cases.

There appears to be a direct cause-and-effect relationship between reduction of funds (reduced activity by our department) and increased incidence.

Among the curtailments was the elimination in 1953 by the legislature of our funds for social hygiene lectures. We had been bringing essential information on "clean living" (sex education, some call it) to high school students at the request of school people by way of two to four full-time, qualified lecturers and counselors ever since soon after World War I.

There may not be a cause-and-effect relationship between curtailment of activity by our department and the subsequent increase in venereal disease, but most of us believe there is.

Perhaps by now you have a concept of some of the more important reasons why we can expect to do less than our share when we move forward together on the next steps to reduce illnesses and deaths by way of attacking the big chronic disease problem. Postgraduate courses for physicians will need to be stepped up in this area, but you will be much better prepared to do your part than we will.

We need your help and understanding. We all need public support and public response in utilizing what we already know and what we can expect to learn from the research programs that are under way. We have done pretty well up to now. We hope for the best in the future. But pious hope won't be enough. We need action.

Remarks of Secretary of State Board of Medical Examiners

Dr. T. W. Tormey, Jr.: The licensing and certifying of individuals under Chapter 147 of the Wisconsin Statutes continues to be more than a mechanical procedure in the eyes of the Board of Medical Examiners. We feel a deep sense of responsibility to the citizens of this state and to our colleagues. Thus, oral interviews and examinations are held to help us in evaluating in each candidate the character, personality, integrity, and interest in the general problems of the sick, as well as his or her medical knowledge.

In this past year more and more questions have arisen in regard to the foreign-trained physician. We have approximately one hundred fifty inquiries a year from these individuals who are graduates of unapproved schools. Not only do the individuals themselves ask about licensure, but their friends, relatives, or potential associates exert varying pressures on the board or the individual board members in their behalf.

While we want to be considerate and helpful to all who apply, we do resent the unwarranted pressures. We must follow the statutes in determining the qualifications of an individual for licensure or certification.

At the last count there were nearly 1,800 United States citizens attending unapproved foreign medical schools. These individuals will soon be coming home and looking for licensure.

Five members of our group attended the annual meeting of the Federated State Boards this year. The subject of the foreign-trained physician (American citizen or foreign-born) demanded the most attention. A Federation committee has been set up to implement a program for screening the foreign-trained individuals, and quite likely the program itself will be organized and approved by the member boards in the next year or two.

This type of program will relieve the various state boards of considerable responsibility in determining the educational status of the graduates of unapproved foreign schools. Until the above situation is clarified, we will continue to do our best for all qualified applicants.

The Temporary Educational Permit program is growing beyond our original conception. In its first year, 1953, we had 17 trainees; but each year since there has been the statutory quota of 25—in fact, this year we have requests for eight more places than are available, and already we are accepting applications for 1957. It would appear that some legislative change might be indicated.

The physical therapy group now numbers 225 registered certificate holders. We are pleased to congratulate Marquette University School of Medicine on graduating its first class in physical therapy this year. A special examination leading to certification has been arranged on May 11 and 12 at the Marquette School of Medicine for this group.

Our investigator, Mr. Don Pressentin, has had an active year from one end of the state to the other. He has continued a fair and impartial investigation of many complaints. The work of the investigator ties in closely with that of the Statutory Grievance Committee; the Grievance Committee of the State Medical Society; and, to some extent, the State Board of Health.

A meeting of our board and the Public Policy Committee of the State Medical Society is planned in the near future to discuss some of our mutual problems in the field of law enforcement, as well as in other fields. May I interject here the thought that our board is interested in all complaints referred to us; but if no legal evidence is presented or uncovered in the course of investigation, we are powerless to take definitive action.

Since our report of May, 1955, we have examined 292 applicants to practice medicine and surgery, 169 by written examination and 123 by oral examination; 24 temporary educational permit individuals from Europe and as far away as the Orient have been interviewed. The Physical Therapy Examining Committee has seen 36 candidates; 14 chiropodists wrote the examination last July. The above repre-

sents a total of 366 individuals who have been examined and interviewed this past year.

The Annual Registry, soon to be in your hands, will list 4,432 individuals. At the present time the board is considering an IBM type of re-registration procedure wherein the original punch card would be in the form of a bank check. This would be properly filled in by the registrant, mailed in, and photographed for permanent record; cashed at his bank; and returned to the signee to act as his registration card. If definite approval is given this plan, more information about it may be published in the Forum section of the Medical Journal.

Remarks of the Dean of the University of Wisconsin Medical School

Dr. John Z. Bowers: I do feel very sincerely that the medical schools of our country are the common property of the medical profession; that it is extremely important that the men who are in the practice of medicine be conversant with the programs of the schools, their problems, and their needs; and that when problems develop or exist it is exceedingly important that these be mutually discussed in an air and atmosphere of friendship and mutual support.

I am sure you will all be proud to know that the number of students graduated by the medical schools of our country increases each year. Last year there were about 6,750 doctors who graduated from these schools, and we can optimistically anticipate that within the next year or two the number will rise significantly above 7,000.

For example, new medical schools are operating in Florida, one at Gainesville and one at Miami. A new medical school has opened in Los Angeles. Missouri, Mississippi, and North Carolina have expanded two-year medical school programs to four-year programs. Seton Hall in Jersey City is opening a medical school in September, and the University of Kentucky is studying the costs and needs to erect a medical school. So production rises in the way of meeting the needs of our country for doctors.

During the past eight years there has been a decrease in the number of applicants to our medical schools. Last year there were about two applicants for each opening in medical schools, which represents a decrease from about 4½ per opening, which applied in 1950.

The number of applicants relates to the general decrease in the number of men and women going to our institutions of higher learning. We anticipate that within the next five years the number of men and women in our country wanting to go to medical school will rise to a point where we will have five or six applicants for each opening.

This means that the problems of how to select medical students are difficult and are quite appropriately receiving a great deal of attention in our medical schools today. It is obvious that we cannot select the best students if we concentrate our attention solely on the grade-point average; and therefore all medical schools, including our medical school at Madison, have diversified the criteria which they consider in selecting medical students.

Obviously, the grade-point average in college is still the best criterion that we have for just how badly a boy or girl wants to go to medical school; but obviously, also, if we stick to that alone we will get some pretty improper and unadvised students in medical school. Therefore, interviews have become increasingly important.

The use of the medical college admission test, which has been developed by the Association of American Medical Colleges, the use of the evaluations of premedical advisers, which are of extreme importance, plus letters of recommendation and general evaluation of the student enter more and more into our process of selection.

I think it is important for doctors to be aware of this because people constantly come to physicians wanting to know what the possibilities and probabilities are of getting their sons or daughters into medical school. Information is easily available, and if there are questions I know that either Dean Hirschboeck or I would be happy to try to answer them for you.

There are two problems in medical education today which I think are of considerable concern to the practicing profession. One of these, which has caused trouble in a number of states, has to do with the practice of medicine by members of medical school faculties.

In Oregon, Washington, Mississippi, Colorado, and Georgia, to mention a few states, there have been violent conflicts between the medical schools and the practicing profession because of the programs to have medical school faculty members see private patients in consultation.

It is quite obvious that there are very few medical schools in our country that can afford to have full-time faculties and to pay them sufficient salaries to hold them. Therefore, the device of having faculty members supplement their incomes by seeing private patients is in existence in practically all of the medical schools in our country. The great problem is to limit this so that the primary focus of the faculty is still on teaching and research and so that faculty members do not become so active in the practice of medicine that other things fall into roles of secondary importance.

In order to have faculties that take this approach, our medical schools have to pay salaries that are sufficient to assure a man of a living wage so the money that he makes in practice is truly only supplemental. Therefore, medical schools in our country are trying to meet this problem by getting additional funds to pay faculty members better salaries so that they will not have to become active in the practice of medicine to a point where their programs materially affect the good relations between the practicing profession and our medical schools.

A second problem—and one which is always present with us—has to do with the cost of medical education. As you know, our government is investing large amounts of money in medical research, to a point where many of our medical schools have incomes for research equal to the amount of money appropriated by the state. That is just about the case in our medical school at Madison. We get in just about as much money from outside sources to support our research programs as we get from the state in our biennial appropriation.

So we have a lot of money for research, but we have very little in the way of facilities to carry on research. There is now in the committees in our Congress in Washington a bill which over a period of three years would appropriate $150,000,000 that would be used on a matching basis to erect facilities for teaching and research in our medical schools. This bill has the approval of the American Medical Association, as a one-shot proposition. It has the strong endorsement of the administration; and if segregration problems do not become too pronounced in regard to legislation for education, there seems to be good reason to believe that this legislation will be effected.

I would like to thank you for the privilege of allowing me to be here. I would impress upon you that if you have questions or problems about medical students and medical schools, I know Doctor Hirschboeck and I will be happy to answer them.

District X Blue Shield

Speaker Fons made the following report concerning Blue Shield plans in the area known as District X:

As you know, Blue Shield plans are essentially autonomous within the particular area served by them. There are 76 such plans throughout the country, and they have associated themselves together in a formal organization known as Blue Shield Medical Care Plans.

This national association of Blue Shield plans meets annually; and under various provisions of its constitution and by-laws, direction of its activities in the interim between annual meetings is conducted by a Commission comparable in many respects to the Council of the State Medical Society. The Commission is composed of both physicians and administrators, some of whom are elected to represent areas and some of whom are commissioners-at-large.

The area, or district, in which Wisconsin participates is known as District X, and our representatives on the national Blue Shield Commission are Mr. Sherin of Iowa Medical Service and Doctor Mason of Wisconsin Physicians Service. We also are favored in another respect, in that Mr. Kelley of Surgical Care is a commissioner-at-large. The Tenth District is composed of Wisconsin, Iowa, Nebraska, Minnesota, and North Dakota.

Representatives of Blue Shield in the Tenth District and representatives of Blue Cross (which has a similar organization) have met annually for a joint program session in the morning and individually have conducted business sessions in the afternoon, the principal purpose of which has been to choose our nominees on an annual basis for membership on the national Commission.

As progress has come about in Blue Shield, it has become apparent that these regions or areas must develop a much more active organization, as many of our sales and related problems are regional rather than national, although most of them in many respects are within the community of our own plan. It is my privilege to serve as chairman of the Tenth District plans this ensuing year. As a result of the national conference just held in Hollywood, Florida, it has been decided that there must come about this increased activity at the district level. As a consequence, I called a special meeting of representatives of the Blue Shield plans who were in Hollywood, who were in full accord; and at this meeting the following motion was passed:

"That the executive directors of the Blue Cross–Blue Shield plans meet at the first opportunity to explore the possibilities of better cooperation between the plans of District X; that they bring with them to this meeting such other personnel as they may desire, including representatives from the respective medical societies who sponsor the plans."

This means increased responsibilities in work for our two executives and for the physicians in direction of our particular programs, and should mean that at least once annually such a district meeting will be held in Wisconsin. I feel that this development should be reported to you; and I shall refer this report to the Reference Committee on Resolutions, inasmuch as it also receives the report of the Commission on Prepaid Plans.

Resolution from Columbia–Marquette–Adams County Medical Society

WHEREAS, the Joint Commission on Accreditation of Hospitals has been, and is, formulating rules which affect the practice of medicine in all our hospitals, and

WHEREAS, we acknowledge the time and effort put in by the members of the Commission in a job in which it is impossible to please all members of the medical profession, and

WHEREAS, the men who practice general medicine are vitally concerned in the rules which govern their hospital practice, and

WHEREAS, there are only two general practitioners, from a total of 20 members, on the present Joint Commission on Accreditation of Hospitals; therefore be it

Resolved, That the State Medical Society of Wisconsin advise the AMA that our State Society urges more adequate representation of the general practitioner on the Joint Commission on Accreditation of Hospitals.

Reference of Reports

Speaker Fons announced referral of reports to the following committees:

To the Reference Committee on Reports of Officers: Reports of the president; president-elect, except that portion relating to the Commission on Prepaid Plans; treasurer; secretary; and AMA Delegates.

To the Reference Committee on Reports of Standing Committees: Reports of the committees on Civil Defense, Cancer, Grievances, Hospital Relations, Military Medical Service, Veterans Medical Service Agency, Council on Medical Service, and Council on Scientific Work, and the supplementary report of the Council.

To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Reports of the Council (in the Annual Report), Commission on Prepaid Plans, and Commission on State

Departments, and supplementary reports; that portion of the president-elect's address having to do with the Commission on Prepaid Plans; resolution of Columbia–Marquette–Adams County Medical Society; Doctor Hildebrand's report for the Polio Advisory Committee; dues for 1957; and report of the Foundation.

Announcement was made of the time and place of the reference committee meetings so that any interested member of the Society might appear to present his views on any matter properly before them.

Certification of Councilor

Secretary Crownhart presented information indicating that the total membership of Milwaukee County had reached 1,154. Under Article IX, Section 2 of the Constitution, there shall be elected one councilor for each 250 members or major fraction thereof. Secretary Crownhart certified to the House that Milwaukee County is therefore entitled to one additional member on the Council.

On motion of Dr. J. H. Houghton, Wisconsin Dells, seconded by Dr. M. T. Morrison, Mount Horeb, carried, the House accepted the secretary's certification that Milwaukee County is entitled to one additional member on the Council and that delegates are entitled to make their nomination for this office at the last session.

Committee on Nominations Selected

Following a councilor district caucus of delegates, on motion of Dr. J. W. Prentice, Ashland, seconded by Dr. T. F. Farrell, Prairie du Chien, carried, the following delegates were approved as members of the Nominating Committee:

District	Nominee
1	L. W. Schrank, Waupun
2	R. W. Kreul, Racine
3	A. A. Quisling, Madison
4	L. L. Olson, Darlington
5	P. B. Mason, Sheboygan
6	George Schwei, Menasha
7	B. C. Dockendorff, Arcadia
8	J. W. Boren, Jr., Marinette
9	M. V. Overman, Neillsville
10	W. C. Henske, Chippewa Falls
11	C. J. Picard, Superior
12	W. J. Houghton, Milwaukee
13	J. D. Leahy, Park Falls

Resolution from Manitowoc County Medical Society

Dr. R. G. Yost, Manitowoc, asked unanimous consent of the House to submit a resolution on behalf of the Manitowoc County Medical Society. On motion of Doctor Yost, seconded by Dr. D. M. Willson, Milwaukee, carried, unanimous consent of the House was given to introduce the following resolution:

WHEREAS, adequate health care demands a smooth functioning relationship between the doctor and the hospital, and

WHEREAS, the respective prerogatives and responsibilities of the doctor and the hospital are defined by tradition or law, and

WHEREAS, there is an apparently growing tendency for hospitals, through their administrators, to assume a dictatorial attitude in medical staff matters which are and should be a prerogative of the medical staff, and which are essential to adequate medical care for the community, and

WHEREAS, it appears that the Joint Commission on Accreditation of Hospitals, through its present methods of inspection and accreditation, casts the hospital administrator in the role of director of the medical staff, a role which is often accepted with vigor and enthusiasm; now, therefore, be it

Resolved, That the Manitowoc County Medical Society requests the House of Delegates of the State Medical Society of Wisconsin

To: Authorize an immediate investigation of the relationship between hospitals and physicians in Wisconsin through appropriate committees of the Society with a report no later than the next Annual meeting of the Society, and preferably before, and

To: Instruct the appropriate committees of the Society and the delegates to the American Medical Association to seek the elimination of arbitrary and unnecessary standards for hospital accreditation, and more adequate representation of general practice on the Joint Commission on Accreditation.

The speaker ruled that the resolution dealt with an ethical problem, and the resolution was referred to the Council without discussion from the floor. Subsequently, the Council referred the resolution to the Reference Committee on Reports of Standing Committees.

Adjournment

The first session of the House of Delegates adjourned at 9:25 p.m. on motion of Dr. E. D. Sorenson, Elkhorn, severally seconded, carried.

SECOND SESSION

Wednesday, May 2, 1956

The second session of the House of Delegates convened at 7:45 p.m., Dr. J. W. Fons, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 48 delegates and 9 alternate delegates entitled to vote at this session of the House of Delegates. In addition, 8 alternate delegates and 1 officer registered their attendance.

On motion of Dr. H. J. Kief, Fond du Lac, seconded by Dr. T. W. Tormey, Jr., Madison, carried, the attendance roll of delegates and alternate delegates totaling 57 was accepted as the official roll of this session of the House, to stand for the entire session.

Introduction of Guests

Speaker Fons introduced the following guests of the House of Delegates:

Dr. W. S. Jones, Menominee, Michigan, president of the Michigan State Medical Society.

Mr. Donald Daugherty, Milwaukee, president-elect of the Marquette Chapter of the Student American Medical Association.

Remarks of the Dean of Marquette University School of Medicine

Dr. John S. Hirschboeck: I am indeed happy to have the opportunity to say a few words to you about medical education.

Medical education has been likened to a three-ring circus, and I think in many ways it really is. The three rings in constant operation are education, research, and service. These are the three functions of a modern medical school. They are going on at the same time under the "big top," and each one of them has its place of importance.

I often feel that sometimes a medical school places one or the other of these out of its proper position. If they are kept in the order of education first and foremost, research second, and service third, the medical school is operating as a medical school. As soon as the service aspects loom into paramount importance, the tail can wag the dog, and similarly with research.

And so it is the duty of administrators of medical education to keep these three functions in proper order. That is quite a job, and I think that is where understanding between medical schools and the medical profession and understanding between medical schools and the public are important.

The public wants medical schools to do almost everything. They expect us to solve all of the illnesses of the world. We are to do the research that finds the cause of and cure for illness. In Congress today we have legislation pending. I believe the Public Health Service alone, in its bill for medical research, has a 60 million dollar appropriation pending. Who is going to be using this money for research? The medical schools.

Eighty-two per cent of all the medical research done in the United States is done in our medical schools. If we are going to do 60 million dollars worth of medical research, we are going to have to have the wherewithal to do it. We are going to have to have the plant, the personnel (which of course is the most important), and the ideas to do all of this.

As I said before, the public expects so much of us. We are to solve the ills of the world. The medical profession, too, has a tendency, and rightfully so—because, after all, you who are in the practice of medicine are the product of the schools, you are what we turned out, you are what represents us to the world—to look to the medical schools for service of a sort. Postgraduate programs, too, in a sense look to the medical schools as the medical mentor of the medical profession, the place where one finally looks to see whether this should or should not be done.

So you see medical education today in the United States has a lot of responsibility that needs support—moral and financial, but fundamentally moral support. This, of course, must come mostly from the medical profession first, and then from the public in general and, we hope, from all people.

My plea this evening is that the men in practice, first of all, think kindly toward their medical school. Each one of us has an alma mater. Each one of us was turned out by a medical school. Maybe the school didn't do the best job it could have done for you. Maybe there were defects in your medical education. After all, human failings are everywhere. However, we are the products of medical schools, and we should look to our alma maters with kindness and consideration.

Second, with that feeling behind us we should give our medical schools all of the support they need—morally first. We should recognize that without medical schools the medical profession will collapse. If all the schools were to close today, the medical profession in 50 years would not exist. It would deteriorate back to the old preceptorship system of centuries past. So we have this responsibility of morally supporting the medical schools.

With that, naturally, comes a financial obligation. If the medical profession does not support the schools financially, who else should? The public? The government? Unless we take as a medical profession leadership in supporting our schools financially, they might fall into hands we would not care to have them fall into.

With these few words I ask that you remember the great role that medical education has played and plays in the United States today. It is a role of education first; research, a terrific role; and service as an ever-increasing role. Be sympathetic toward our needs. If you don't understand what our problems are, I am sure that anyone in medical education would be very happy to discuss them with you and try to point out why sometimes the misunderstandings that seem to develop here and there occur and are really not worthy of much discussion.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee was composed of Drs. S. A. Morton, Milwaukee, chairman; E. W. Humke, Chilton; F. A. Gruesen, Fort Atkinson; J. H. Houghton, Wisconsin Dells; and C. E. Koepp, Marinette. Doctor Morton presented the report.

REPORT OF THE PRESIDENT

The reference committee commended Dr. Ervin L. Bernhart for the energetic way in which he has carried on the affairs of the Society. Attention was drawn to his remarks concerning the new Society headquarters and the invitation to all members to visit the new office.

The "special service benefit contract," recently instituted by Wisconsin Physicians Service, is a significant milestone in the history of prepaid medical care plans, not only in our state but in the nation.

The reference committee commended Doctor Bernhart for emphasizing the role of the family physician, particularly in rural health, mental health, and care of the aging.

The reference committee made special note of the fact that Mr. Robert B. Murphy, Society legal counsel, was an active force in presenting the views of the doctors at a hearing on Bill H.R. 7225 in regard

to social security amendments. It is encouraging to note also that Mr. Folsom, Secretary of Health, Education, and Welfare, seems to indicate that his thinking parallels to a large extent that of the doctors in this matter.

It is exceedingly timely that the president has drawn to the attention of the Society the necessity of accident prevention in connection with automobile hazards, and his suggestion that the doctors set the pace by installing safety belts in their own automobiles is a fine one. The reference committee agreed with Doctor Bernhart that physicians should be ever mindful of the accident hazards in the home as well as on the highway and should take an active part in their prevention.

Upon motion of Doctor Morton, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, this portion of the report was accepted.

REPORT OF THE PRESIDENT-ELECT

Doctor Simenstad's able address contained many items that may require further study and action on the part of the House of Delegates and the Council. His proposal that the officers of the constituent county societies be invited at times to attend Council, Commission, or committee meetings seems like a suggestion that would result in doing much to acquaint the members of the county societies with the many activities of their state organization.

It was the consensus of the reference committee that the "Medical Forum" section of *The Wisconsin Medical Journal* seems adequate to cover the functions of a newsletter to the members.

The reference committee expressed pleasure at Doctor Simenstad's interest in the problems handled by the interprofessional institutes. Only by correlating the work of the several health agencies can medicine improve its relations with allied groups and develop an understanding of their problems.

Doctor Simenstad pointed out the difficulties that arise because of the varying Blue Shield contracts held by people living near the borders of contiguous states, and his suggestion that some effort should be made to promote uniformity in contract administration should be followed.

The reference committee was particularly pleased with Doctor Simenstad's emphasis on the duties of the physician, not only serving on various posts in our organization, but also taking a lead in various community matters. The education of the doctor fits him admirably for many of these community activities, and the regard in which the public holds the doctor will be enhanced if he takes an interest in public affairs. The physician who serves in this way, whether it be in medical organizations or in lay groups, is deserving of high praise rather than criticism.

On motion of Doctor Morton, seconded by Dr. E. W. Humke, Chilton, carried, this portion of the report was accepted.

REPORT OF THE TREASURER

The reference committee expressed its satisfaction at a well-documented report on the financial standing of the Society and expressed its sincere appreciation for Doctor Weston's continued service as treasurer.

On motion of Doctor Morton, seconded by Dr. D. M. Willson, Milwaukee, carried, this portion of the report was accepted.

REPORT OF THE SECRETARY

The committee pointed to the many activities of the Society reviewed in the report of the secretary, Mr. Crownhart. It is interesting to note that statistical data of the Society will be more readily available through the use of new machine methods, and this information should be extremely helpful in planing the Society's programs and projects in many fields. The reference committee commended the work of the secretary's office in having available posters, pamphlets, and other media for lay education.

The reference committee noted with interest the secretary's concern over the problem of health insurance for the aging and others not covered by present-day insurance contracts. Further study of this problem was suggested.

The committee gave emphasis to the tremendous amount of time and effort given by the secretary, the assistant secretaries, and the other staff members to the furthering of the progress of medicine through the activities of the State Medical Society of Wisconsin. On many occasions, their duties require much more in the expenditure of time and energy than could be reasonably expected of them; and for all of these things, the Society is grateful.

On motion of Doctor Morton, seconded by Dr. M. V. Overman, Neillsville, carried, this portion of the report was accepted.

REPORTS OF AMA DELEGATES

The committee reviewed the published reports of the delegates from the Society to the American Medical Association which were circulated to the entire membership following the interim meeting of the AMA in Boston and also following the annual meeting held in Atlantic City. The Society should be proud that Dr. Gunnar Gundersen of Wisconsin is now chairman of the Board of Trustees of the AMA. In the delegates' reports, it was noted that the problems taken up at the AMA meetings were in many cases the same problems that have been the concern of the Wisconsin Society for many years.

The reference committee drew particular attention of the delegates to that portion of the report of the AMA delegates concerning hospital practice. Commendation was given the action of the Wisconsin delegates to the AMA of recommending that doctors have a primary voice in the regulation of medical practice in the hospital.

The problems in connection with H.R. 7225 were covered in the president's report, but the reference committee commended the activities of the delegates to the AMA for their position on the bill.

Special attention was drawn to the action of the AMA in setting up a committee to review the functions of the Joint Commission on Accreditation of Hospitals and the report which the Commission

made in June. The reference committee noted the appointment of an AMA Committee on Medical Practice and urged the delegates to the AMA to work toward the development of a study of the relative value of all types of medical and surgical procedures and the stimulation of departments of general practice in medical schools.

On motion of Doctor Morton, seconded by Dr. G. E. Collentine, Milwaukee, carried, this portion of the report was accepted.

REPORT OF STATE HEALTH OFFICER

The reference committee expressed appreciation for the excellent presentation by Dr. Carl Neupert, State Health Officer. The committee said it looks with concern upon the problems he presented and hopes that satisfactory solutions will be found.

REPORTS OF DEANS OF THE MEDICAL SCHOOLS

The reports of Dr. John Bowers, dean of the University of Wisconsin Medical School, and Dr. John Hirschboeck, dean of Marquette University School of Medicine, were most informative and encouraging. They pointed out to the delegates the problems that will face medical education in the next few years. The reference committee expressed its appreciation for the opportunity of having these vital matters brought to the attention of the House for its consideration.

REPORT OF THE PRESIDENT OF THE WOMAN'S AUXILIARY

The committee received the report of the president of the Woman's Auxiliary with great interest and said the activities of the Auxiliary are to be commended.

On motion by Doctor Morton, seconded by Dr. J. H. Houghton, Wisconsin Dells, carried, this portion of the report was accepted.

On motion of Doctor Morton, seconded by Dr. F. E. Drew, Milwaukee, carried, the report as a whole was adopted.

REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES

This reference committee was composed of Drs. G. W. Carlson, Appleton, chairman; G. C. Hank, Madison; A. J. Baumann, Milwaukee; D. N. Goldstein, Kenosha; and R. S. Hirsch, Viroqua. Doctor Carlson presented the report.

COMMITTEE ON CIVIL DEFENSE

The reference committee expressed the belief that the delegates should be aware of real progress being made in civil defense in recent years. At least 46 of the 100 mobile medical teams are already fully organized. While civil defense may never be completely ready to cope with every eventuality, both the medical profession and the public must wage a constant fight against apathy and must make every effort to be as prepared as possible for disaster of any type.

The reference committee recommended that several sections of the report of the Committee on Civil Defense as printed in the *Annual Report for Delegates* be clarified by restatement as follows:

1. The mobile medical team plan should be retained. Two physicians should be designated as captain and co-captain of each team. In the selection of these physicians, county medical societies which have not done so are advised to follow the example of those societies that have been most successful, soliciting volunteers who are interested rather than assigning physicians purely on a mandatory or duty basis.

These individuals should be given the responsibility by their county medical societies of designating a team business manager and maintaining a close liaison with local, county, and regional civil defense officials; being fully acquainted with civil defense procedures in event of disaster; and maintaining a special interest in medical aspects of civil defense and casualty care. They would have full knowledge of supplies, transportation, and operation of their teams in the event they were called into action.

2. Since in 1955 the Legislature approved a new civil defense law making it mandatory for every town, village, city, and county to have a civil defense group, physicians are obligated to learn the fundamentals of disaster planning and to familiarize themselves with the plans of local civil defense directors.

3. The Assistant Co-Director of Health Services in State Civil Defense should continue his excellent work in assisting with the organization of medical teams. Increasing attention should be devoted to educational efforts among the team captains and business managers.

On motion of Doctor Carlson, seconded by Dr. R. S. Hirsch, Viroqua, carried, this portion of the report was accepted.

COMMITTEE ON MILITARY MEDICAL SERVICE

The reference committee noted that this committee continues to do a yeoman job and recommended that Dr. Frank Weston receive the commendation of all physicians for his fine leadership in guarding the interests of both doctors and the public while providing essential health personnel for the armed forces.

On motion of Doctor Carlson, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

VETERANS MEDICAL SERVICE AGENCY OPERATING COMMITTEE

The reference committee reviewed the report of the Veterans Medical Service Agency Operating Committee, under the chairmanship of Doctor Supernaw, and expressed the belief that the Home Town Care Program for veterans with service-connected disabilities has been a good program for veterans and that attempts should be made to continue it. Since no specific decision apparently is required prior to the next session of the House of Delegates,

the reference committee recommended that the matter be left in the hands of the Council for negotiation.

On motion of Doctor Carlson, seconded by Dr. T. W. Tormey, Jr., Madison, carried, this portion of the report was accepted.

COMMITTEE ON CANCER

The committee concurred with the recommendations of the Committee on Cancer, so ably headed by Doctor Conley. Special attention was directed to various forms of quackery, and the committee urged county cancer committees to participate in the State Medical Society's broad study on chiropractic and quackery and that efforts be made to assist physicians and laymen in their understanding of new and unusual claims for the cure or relief of this disease. The reference committee urged all physicians to give more attention to the treatment and follow-up care of cancer patients. Reassurance and personal guidance of those so afflicted will discourage the cancer patients from turning to quacks or other types of unscientific and unrecognized care and treatment.

On motion of Doctor Carlson, seconded by Dr. M. T. Morrison, Mount Horeb, carried, this portion of the report was accepted.

COMMITTEE ON GRIEVANCES

The Committee on Grievances was commended for its continued excellent service. Doctor Fitzgerald and his excellent committee have continued to serve in the best interests of better patient-physician relationships. Attention was drawn to the complex scope of the activities of the committee and its aims.

On motion of Doctor Carlson, seconded by Dr. S. E. Zawodny, Milwaukee, carried, this portion of the report was accepted.

COMMITTEE ON HOSPITAL RELATIONS

The reference committee reviewed the resolutions from the Manitowoc County Medical Society and the Columbia-Marquette-Adams County Medical Society, along with the report of the Committee on Hospital Relations, all concerned with accreditation and physician-hospital relations. It was the opinion of the reference committee that the intent of these resolutions was incorporated in an action of the Council on February 26, 1956, authorizing the Council on Medical Service, the Committee on Hospital Relations, and other appropriate committees to undertake a joint study of relationships between hospitals and physicians and to present a report at the next annual session of the House of Delegates. The reference committee recommended early implementation of the study.

On motion of Doctor Carlson, seconded by Dr. A. J. Baumann, Milwaukee, carried, this portion of the report was accepted.

COUNCIL ON MEDICAL SERVICE

Special commendation was given to the Council on Medical Service and its chairman, Doctor Devitt, for taking medicine's case for better health to the public through mass communication. The committee also called attention to the placement service of the Society, which has been so helpful in finding locations for physicians and assisting communities which need medical service. Continuation of the active public education and public relations program as outlined in the report of the committee was recommended.

On motion of Doctor Carlson, seconded by Dr. A. A. Quisling, Madison, carried, this portion of the report was accepted.

COUNCIL ON SCIENTIFIC WORK

Special commendation was given to Dr. S. A. Morton and the members of the Council on Scientific Work for their preparation of an outstanding Annual Meeting program this year. The meeting merits continued support by the attendance of all physicians, for it presents a program so diversified as to appeal to the entire membership.

The reference committee recommended that the proposals made by Doctor Morton with reference to a coordinated postgraduate education program in Wisconsin be accepted and implemented by the Council on Scientific Work with the general Council.

On motion of Doctor Carlson, seconded by Dr. E. W. Humke, Chilton, carried, this portion of the report was accepted.

In addition, the reference committee recommended that the House commend all committee members for their efforts on behalf of the Society, outside of their practice, in the interests of public health, and recognize the able assistance rendered by the office staff in Madison on behalf of the Society. On motion of Doctor Carlson, seconded by Dr. D. N. Goldstein, Kenosha, carried, this portion of the report was accepted.

On motion of Doctor Carlson, seconded by Dr. F. E. Drew, Milwaukee, carried, the report as a whole was adopted.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS

This reference committee was composed of Drs. T. W. Tormey, Jr., Madison, chairman; D. M. Willson, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; and E. D. Sorenson, Elkhorn. Doctor Tormey presented the report.

REPORT OF THE COUNCIL

The divergent activities of the Council were reviewed, and the reference committee expressed satisfaction that the wide variety of Society activities was considered in detail at each of the Council meetings.

The reference committee expressed interest in the forthcoming Council meeting on economic matters, at which it is anticipated there will be discussion not only of matters concerned with the Commission on Prepaid Plans, but of the financial responsibilities of such projects as that proposed by Doctor Morton of the Council on Scientific Work; the Charitable, Educational, and Scientific Foundation; and others. The reference committee wholeheartedly

agreed with the Council's recommendations, both during the year and at its April 29 meeting, as to the Principles of Medical Ethics. It particularly commended the AMA for its suggestion that, in the future, changes in the Principles not be acted upon until the session following that in which introduced. The reference committee commended the suggestion of the Council that proposed changes in the Principles of Medical Ethics be a matter of special notice to AMA delegates and officers of state medical societies and recommended that this suggestion be forwarded to the American Medical Association.

On motion of Doctor Tormey, seconded by Dr. H. A. Aageson, Oconto, carried, this portion of the report was accepted.

The liaison between the general Council and the Council on Scientific Work, as demonstrated by their joint meeting in July, 1955, was recognized as a fine effort in laying the groundwork for the program of the Annual Meeting. The reference committee urged that these joint meetings be continued.

Attention was drawn to Council approval of a recommendation of the Division on Nervous and Mental Diseases (of the Commission on State Departments) opposing certification by law of clinical psychologists as being unwise at this time since those in the clinical psychological field who treat mental diseases would in fact be treating the sick, and doctors of philosophy in the field of psychology are not trained in the medical sciences.

The reference committee agreed that certification of this group by state law was premature at this time and opposed such certification but recommended encouragement of voluntary certification through the devices of the group's own organization.

On motion of Doctor Tormey, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

The Council was commended for its position in the anti-fluoridation campaigns and its proposed study of public health laws in an effort to bring them up to date. The reference committee recognized that such a study cannot be completed in a short time but recommended that the House look forward to a progress report in another year. The Council was commended on its resolution on the Governor's Conference on an Aging Population and in particular on the recommendation that county societies designate at least one physician to participate in a special discussion on June 7 entitled "The Role of the County Medical Society in the Care of the Aging." The committee urged the House to adopt the resolution and recommended that all county medical society officers be notified of it.

On motion of Doctor Tormey, seconded by Dr. J. W. Boren, Jr., Marinette, carried, this portion of the report was accepted.

COMMISSION ON PREPAID PLANS

The theme of the report of the Commission, "A Look to the Future," was endorsed by the reference committee; and the Commission was commended for its foresight and willingness to enlarge the scope of its coverage and activity and particularly for the new special service contract which is currently in effect in several areas of the state. The new and experimental program has attracted nationwide attention.

The reference committee noted the report of Speaker Fons dealing with the recommendation that Blue Cross and Blue Shield plans within their own districts need to explore the possibilities of better cooperation among them. It urged that this recommendation be followed in the Tenth District and pointed out that such a plan might result in a district meeting being held at least once annually in Wisconsin.

The committee pointed to Doctor Simenstad's suggestion that at least one county medical society meeting per year or, if necessary, a district meeting be devoted to acquainting the Medical Society members at the local level with problems in the field of Blue Shield.

The reference committee stated that all of these activities are indications of the interest and work of the Commission on Prepaid Plans and the medical profession in Wisconsin generally in an effort to bring more and more economic medical protection to the people of Wisconsin.

On motion of Doctor Tormey, seconded by Dr. S. A. Morton, Milwaukee, carried, this portion of the report was accepted.

COMMISSION ON STATE DEPARTMENTS

Commendation was given to the continuing activities of the Commission on State Departments and the many participating physicians and state department representatives for their interest and efforts in vital phases of medical practice and public health in Wisconsin. The reference committee urged Medical Society and professional support of the Maternal Mortality Study Committee and its contributions in reducing maternal mortality and morbidity; the fetal-neonatal study of the Division on Maternal and Child Welfare and its short courses for police officers; activities in handling the problem of tuberculosis in mental institutions; continued activities in the School Vision Screening Program; revision of the "Guide on Hearing Conservation Programs for Wisconsin Industries"; school health conferences; "Medical Care Standards," known as Chapter V of the Department of Public Welfare; and the newly created Division on Safe Transportation dealing with the health factors in automobile fatalities. Physicians were urged to submit suggestions relative to possible projects or implementation of projects to the chairmen of the various divisions of the Commission. Special attention was called to the serious menace of tuberculosis; and it was pointed out that, because of changed methods of therapy in this disease, the bed occupancy of county and state facilities has declined to a point where institutions are confronted with the alternatives of closing or accepting patients without tuberculosis. The committee pointed out that the 1955 Legislature passed a law to permit dual use of facilities originally established to care for tuberculosis patients alone. The committee recommended adoption of the proposed statement of policy regarding the use of county tuberculosis facilities as proposed by the Division on Tuberculosis and Chest Diseases.

On motion of Doctor Tormey, seconded by Dr. E. D. Sorenson, Elkhorn, carried, this portion of the report was accepted.

The committee reviewed a report of the project dealing with fetal-neonatal mortality which had been distributed to the House at its first session. The reference committee felt that the report would be helpful in developing educational programs and in stimulating local hospital staffs to undertake similar studies of their own experiences. It offers hospitals something to use in making comparative analyses and in measuring future progress. The reference committee recommended that copies of the report be made available to members of the division, to hospitals which participated in the study, and to physicians who served as members of the study teams. It was also suggested that some of the data be included in slides made to be used in medical lectures to hospital staff or county society meetings, much as information from the Maternal Mortality Study is currently being used.

On motion by Doctor Tormey, seconded by Dr. D. M. Willson, Milwaukee, carried, this portion of the report was accepted.

The reference committee called for further amplification of the Fetal-Neonatal Mortality Study by Dr. Robert F. Purtell, Milwaukee, chairman of the Division on Maternal and Child Welfare. His report to the delegates follows:

Dr. Robert F. Purtell: The Fetal-Neonatal Study Report that was handed to you last night represents the cumulative work of about three years by nearly 100 physicians in Wisconsin, and it would be unfortunate if it were given to you simply as a mass of statistical data. I shall not attempt to break down this report tonight; it is something that should be read and reread. It was the No. 2 project of the Division of Maternal and Child Welfare.

During 1954 there were approximately 92,000 births in the State of Wisconsin. There were about 2,200 fetal and neonatal deaths. When the Division took upon themselves the making of this study, we knew we were dealing with a number so large that it would be impractical to try to study every single fetal-neonatal death, so we arbitrarily selected 42 hospitals, those hospitals having a pathologist. There were some hospitals that were not invited to participate which asked that they be allowed to participate, and we therefore included them.

This report comprises data on about two-thirds of the total fetal-neonatal deaths during 1954, so it is a very accurate cross section of what is happening in Wisconsin.

There are some things that I believe you should take back to your county medical societies. Our record in Wisconsin is good—as good as in the rest of the country. The natal-day deaths still are with us, and the study did turn up things that we certainly can improve upon. There were too many fetal-neonatal deaths that had too little data pertaining to prenatal care and many other parts of the questionnaire; there I think we could improve our practice.

The problem of obstetrical anesthesia is with us, and the Division has appointed a special subcommittee to make an obstetrical survey. This is not in the planning stage; it has been started.

I urge all of you to review this report very carefully. We selected 17 teams comprising four men each—a general practitioner, an obstetrician, a pediatrician, and a pathologist. That is quite a few men scattered all over the state. The response was marvelous. Some of the comments that came in accompanying these reports would be well worth hearing if only the House had time tonight. They were evidence of the enthusiasm and readiness of the doctors all over the state to work with this Division in this project.

Take the report home; bring it before your staff. I am sure the State Society will put out lantern slide material which will visually dramatize the report.

As I step aside as chairman of this wonderful Division, which I always like to refer to as a team, may I say that I don't think there is anything I have done in the last 10 or 20 years with more reluctance than deciding I had to step aside as chairman of the Division.

Before I leave I would like to remind the delegates of our good fortune in having Dr. Amy Louise Hunter, of the State Division on Maternal and Child Care, working with this Division. It was she who prepared the fetal-neonatal report that you have in your hands. Her industry and enthusiasm are simply beyond description.

Finally, I'd like to express appreciation to that dynamic ball of fire whom you all know and without whom our Division would not have functioned as splendidly as it did in the past several years—Roy Ragatz.

I want to wish the Division and my successor, Doctor Kilkenny, the best of good fortune.

POLIOMYELITIS ADVISORY COMMITTEE

The reference committee explained that it had carefully reviewed the detailed history of the Committee on the Use and Distribution of the Vaccine Against Poliomyelitis by Doctor Salk as submitted by Dr. W. B. Hildebrand, Menasha, chairman.

The reference committee pointed out that this date marked the anniversary of the first meeting of the committee and that much has been accomplished in the first year. It felt that the committee, in conjunction with the State Board of Health, accomplished an excellent program for the equitable distribution of the Salk vaccine.

The primary job of the committee has been to lay down broad concepts for action and implementation within the state which it has felt would be in the best public interest. Through the activity of that committee, approximately 35% of the eligible persons in the state have been given the two recommended injections during the first year.

Since April 26, 1956, it has been announced that the vaccine is again available for distribution to the physician on his request to the State Board of Health. Physicians are urged to continue to participate in the program and to complete the project as rapidly as the vaccine is available.

Doctor Hildebrand and his committee and Doctor Neupert and the State Board of Health staff were highly commended for their active part in this vital health project in Wisconsin.

On motion of Doctor Tormey, seconded by Dr. S. E. Zawodny, Milwaukee, carried, this portion of the report was accepted.

CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INCORPORATED

The report of the Charitable, Educational, and Scientific Foundation, as presented by its president, Doctor Bernhart, was reviewed by the committee. The committee felt the Foundation was another indication of the continuing growth of the Society and its interest in not only the economics of medicine but the history and future of the profession. All members of the Society were urged to look forward with interest to the progress of such projects as the restoration of the military hospital at Fort Crawford and those in research and education. The trustees of the Foundation recommended, and the reference committee approved, that each active member of the State Medical Society of Wisconsin be invited to contribute, on a voluntary basis, the sum of $10 to the Foundation for the fiscal year beginning July 1, 1956.

On motion of Doctor Tormey, seconded by Dr. C. J. Picard, Superior, carried, this portion of the report was accepted.

With reference to dues, the reference committee reported that the continually increased activities of the State Medical Society, with still additional projects such as that of Doctor Morton concerning consolidation of postgraduate medical education, made it apparent that the present dues structure of the Society must be maintained. The reference committee suggested, however, that the Council, through its committees, study all phases of activities carefully and report on the cost of unusual or additional projects. At this time, there does not appear to be an indication for an increase in dues.

On motion of Doctor Tormey, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, this portion of the report was accepted.

On motion of Doctor Tormey, seconded by Dr. John Beffel, Milwaukee, carried, the report as a whole was adopted.

Medical Students in Society Employ

Mr. Crownhart reported to the House that the officers and staff take considerable pride in the fact that in recent years they have been able to bring into the administrative side of medicine medical students in the employ of the State Medical Society. At first, only one medical student was employed, then two; and Mr. Crownhart indicated that by next summer there will be four. One of those medical students, Mr. Robert Taake, was present. Mr. Crownhart introduced him and reported that Mr. Taake works in the Auditing Department of Wisconsin Physicians Service. He said that the medical students keep the nonmedical members of the staff alert, and it is interesting to note how often they have "waked up" the Claims Committee to erroneous judgment.

Adjournment

On motion of Doctor Tormey, seconded by several, carried, the second session of the House of Delegates adjourned at 9 p.m.

THIRD SESSION

Thursday, May 3, 1956

The third session of the House of Delegates convened at 8:45 a.m., Dr. J. W. Fons, Speaker of the House, presiding.

Report of Committee on Credentials

The Committee on Credentials verified the registration of 45 delegates and 9 alternate delegates entitled to vote at the third session of the House of Delegates. In addition, 7 alternate delegates registered their attendance.

On motion by Dr. H. J. Kief, Fond du Lac, seconded by Dr. D. M. Willson, Milwaukee, carried, the attendance roll of delegates and alternate delegates totaling 54 was accepted as the official roll of the third session of the House of Delegates, to stand for the entire session.

Report of Committee on Nominations

Dr. A. A. Quisling, Madison, chairman of the Committee on Nominations, presented the names of the following nominees for official positions in the State Medical Society:

For President-Elect: Dr. H. E. Kasten, Beloit
For Speaker of the House: Dr. J. W. Fons, Milwaukee
For Vice-Speaker of the House: Dr. W. B. Hildebrand, Menasha
For Delegate to the AMA to succeed Dr. S. E. Gavin, Fond du Lac: Doctor Gavin
For Delegate to the AMA to succeed Dr. D. H. Witte, Milwaukee: Doctor Witte
For Delegate to the AMA to succeed Dr. J. C. Griffith, Milwaukee: Doctor Griffith
For Alternate Delegate to the AMA to succeed Dr. L. O. Simenstad, Osceola: Doctor Simenstad
For Alternate Delegate to the AMA to succeed Dr. E. L. Bernhart, Milwaukee: Doctor Bernhart
For Alternate Delegate to the AMA to succeed Dr. R. E. Galasinski, Milwaukee: Doctor Galasinski

On motion of Dr. G. W. Carlson, Appleton, seconded by several, carried, Doctor Kasten was unanimously elected to the office of president-elect. Speaker Fons appointed Dr. A. A. Quisling, Madison; Dr. C. J. Picard, Superior; and Dr. M. D. Davis, Milton, as a special committee to inform Doctor Kasten of the election and escort the president-elect to the platform.

Doctor Fons then called upon Vice-Speaker Kief to assume the chair. On motion of Dr. R. W. Mason, Marshfield, seconded by Dr. E. W. Humke, Chilton, carried, Doctor Fons was unanimously elected Speaker of the House. Doctor Fons then resumed the chair.

On motion of Dr. David Regan, Neenah, seconded by Dr. D. M. Willson, Milwaukee, carried, Dr. W. B. Hildebrand, Menasha, was unanimously elected to the office of Vice-Speaker of the House.

On motion of Dr. L. W. Schrank, Waupun, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, Dr. S. E. Gavin, Fond du Lac, was unanimously re-elected delegate to the AMA.

On motion of Dr. F. E. Drew, Milwaukee, seconded by Dr. J. E. Conley, Milwaukee, carried, Dr. D. H. Witte, Milwaukee, was unanimously re-elected as delegate to the AMA.

On motion of Dr. P. B. Mason, Sheboygan, seconded by Dr. M. T. Morrison, Mount Horeb, carried, Dr. J. C. Griffith, Milwaukee, was unanimously re-elected as delegate to the AMA.

On motion of Dr. L. W. Schrank, Waupun, seconded by Dr. A. A. Quisling, Madison, carried, Dr. L. O. Simenstad, Osceola, was unanimously re-elected to serve as alternate delegate to the AMA for Doctor Gavin.

On motion of Dr. J. D. Leahy, Park Falls, seconded by Dr. A. J. Sanfelippo, Milwaukee, carried, Dr. E. L. Bernhart, Milwaukee, was unanimously re-elected alternate delegate to the AMA for Doctor Witte.

On motion of Dr. S. E. Zawodny, Milwaukee, seconded by Dr. A. J. Baumann, Milwaukee, carried, Dr. R. E. Galasinski, Milwaukee, was unanimously re-elected to serve as alternate delegate to the AMA for Doctor Griffith.

Speaker Fons announced that Milwaukee had been selected by the Nominating Committee as the site for the 1957 Annual Meeting of the State Medical Society. On motion of Dr. D. M. Willson, Milwaukee, seconded by several, carried, Milwaukee was selected for the site of the 1957 Annual Meeting.

Election of Councilors

The House then proceeded to the election of Councilors, with the following results:

In the Seventh District, on nomination of Dr. B. C. Dockendorff, Arcadia, seconded by Dr. R. S. Hirsch, Viroqua, carried, Dr. J. C. Fox, La Crosse, was unanimously re-elected.

In the Eighth District, on nomination of Dr. H. C. Marsh, Shawano, seconded by several, carried, Dr. J. M. Bell, Marinette, was unanimously re-elected.

In the Ninth District, on nomination of Dr. M. V. Overman, Neillsville, seconded by several, carried, Dr. R. E. Garrison, Wisconsin Rapids, was unanimously re-elected.

In the Tenth District, on nomination of Dr. H. F. Pagel, Ladysmith, seconded by several, carried, Dr. R. G. Arveson, Frederic, was unanimously re-elected.

In the Twelfth District, on nomination of Dr. A. J. Baumann, Milwaukee, seconded by several, carried, Dr. J. E. Conley, Milwaukee, was unanimously elected.

In the Thirteenth District, on nomination of Dr. Marvin Wright, Rhinelander, seconded by several, carried, Dr. J. D. Leahy, Park Falls, was unanimously elected to succeed Dr. W. P. Curran, Antigo.

Acceptance by the President-Elect

Dr. H. E. Kasten was escorted to the platform by the special committee appointed by the Speaker. In his address of acceptance, Doctor Kasten made the following remarks:

"It is in the spirit of greatest humility that I express to you my heartfelt and sincere appreciation for the honor you have conferred upon me this morning; and in return for the great trust and confidence that you have placed in me, I hereby make my solemn promise that I will at all times, to the best of my very inadequate ability, carry on in the finest tradition of Wisconsin medicine."

Doctor Wilson Introduced

Speaker Fons introduced Dr. R. H. Wilson, president of the Minnesota State Medical Association, who extended the greetings of his association.

Adjournment *Sine Die*

On motion of Dr. F. E. Drew, Milwaukee, seconded by several, carried, the House of Delegates adjourned, *sine die*, at 9:15 a.m.

ICS ANNUAL CONGRESS

The 21st Annual Congress of the United States and Canadian Sections, International College of Surgeons, will be held in the **Palmer House, Chicago, September 9–13.**

General assemblies will be held mornings and afternoons Monday, September 10, through Thursday, September 13. **Section meetings** at the same hours will cover coloproctologic surgery, neurosurgery, obstetrics and gynecologic surgery, occupational surgery, ophthalmology and otorhinolaryngology, orthopedic surgery, plastic surgery, rehabilitation services, surgical nurses, and urologic surgery.

A **film forum** will be presented on Monday evening. All-day **scientific motion picture programs** will be given Monday through Thursday.

The **annual banquet** will be on Wednesday evening. The **annual convocation** will take place in the Civic Opera House on Thursday evening.

A special **post-assembly clinical day**, open to all physicians, will be held in the Cook County Hospital on Friday, September 14.

Dr. Raymond W. McNealy, Chicago, is general chairman, and Dr. Peter A. Rosi, Chicago, program chairman.

For further information, write the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

Attendance at House of Delegates
May 1, 2, and 3, 1956

Society	*Physicians**	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	x	x	x
	J. M. Jauquet, Ashland	o	o	o
Barron–Washburn–Sawyer–Burnett	J. R. Guy, Barron	o	o	o
	R. C. Thompson, Cumberland	o	o	o
	H. M. Templeton, Barron	x	x	o
Brown–Kewaunee–Door	L. C. Miller, Green Bay	x	x	x
	J. A. Ford, Green Bay	o	o	o
	R. M. Waldkirch, De Pere	x	x	x
	S. L. Griggs, Green Bay	o	o	o
Calumet	E. W. Humke, Chilton	x	x	x
	A. C. Engel, New Holstein	o	o	o
Chippewa	W. C. Henske, Chippewa Falls	x	x	x
	J. J. Sazama, Chippewa Falls	o	o	o
Clark	M. V. Overman, Neillsville	x	x	x
	R. L. Hansen, Colby	x	o	o
Columbia–Marquette–Adams	J. H. Houghton, Wisconsin Dells	x	x	x
	R. F. Inman, Montello	x	x	x
Crawford	T. F. Farrell, Prairie du Chien	x	x	x
	O. E. Satter, Prairie du Chien	o	o	o
Dane	J. R. Steeper, Madison	x	o	x
	R. A. Straughn, Madison	x	x	x
	M. T. Morrison, Mount Horeb	x	x	x
	V. W. Nordholm, Stoughton	o	o	o
	T. W. Tormey, Jr., Madison	x	x	x
	R. M. Becker, Madison	o	o	o
	C. W. Stoops, Jr., Madison	x	x	x
	R. P. Sinaiko, Madison	o	o	o
	G. C. Hank, Madison	x	x	x
	R. J. Hennen, Madison	o	o	o
	A. A. Quisling, Madison	x	x	x
	E. J. Nordby, Madison	o	o	o
	P. B. Golden, Madison	x	x	o
	A. P. Schoenenberger, Madison	x	x	x
Dodge	L. W. Schrank, Waupun	x	x	x
	H. G. Bayley, Beaver Dam	x	o	o
Douglas	C. J. Picard, Superior	x	x	x
	H. A. Sincock, Superior	o	o	o
Eau Claire–Dunn–Pepin	Robert Lotz, Eau Claire	x	x	x
	O. G. Moland, Augusta	x	x	x
Fond du Lac	H. J. Kief, Fond du Lac	x	x	x
	Howard Mauthe, Fond du Lac	x	x	o
Forest	E. F. Castaldo, Laona	o	o	o
	B. S. Rathert, Crandon	o	o	o
	O. S. Tenley, Wabeno	x	x	o
Grant	M. W. Randall, Boscobel	x	x	x
	E. C. Howell, Fennimore	o	o	o
Green	B. H. Brunkow, Monroe	x	x	x
	J. R. Weir, Monroe	o	o	o
Green Lake–Waushara	V. J. Taugher, Berlin	x	o	o
	R. D. Wichmann, Wild Rose	o	o	o
Iowa	C. L. White, Mineral Point	o	o	o
	S. B. Marshall, Hollandale	x	o	x
Jefferson	F. A. Gruesen, Fort Atkinson	x	x	x
	R. W. Quandt, Jefferson	o	o	o
Juneau	J. E. Thompson, Mauston	x	x	x
	V. M. Griffin, Mauston	o	o	o
Kenosha	D. N. Goldstein, Kenosha	o	o	x
	H. L. Schwartz, Kenosha	o	o	o
La Crosse	R. L. Gilbert, La Crosse	o	o	o
	J. P. McCann, La Crosse	x	x	x
	J. L. Jaeck, La Crosse	o	o	o
	F. H. Wolf, La Crosse	x	o	o
	L. R. Schmidt, La Crosse	o	o	o
Lafayette	L. L. Olson, Darlington	x	x	x
	D. J. Garland, Shullsburg	o	o	o
Langlade	B. W. Beattie, Antigo	x	x	x
Lincoln	R. G. Baker, Tomahawk	o	o	o
	K. A. Morris, Merrill	x	x	x
Manitowoc	R. G. Yost, Manitowoc	x	o	o
	N. A. Bonner, Manitowoc	x	o	o
Marathon	D. M. Green, Wausau	x	x	o
	E. P. Ludwig, Wausau	x	x	x
Marinette–Florence	C. E. Koepp, Marinette	o	o	o
	J. W. Boren, Jr., Marinette	x	x	x
Milwaukee	A. J. Baumann, Milwaukee	x	x	x
	E. A. Habeck, Milwaukee	o	o	o
	J. B. Wilets, Milwaukee	o	o	o
	R. E. Callan, Milwaukee	x	x	x
	R. F. Purtell, Milwaukee	x	x	x
	D. W. Ovitt, Milwaukee	o	o	o
	S. L. Chojnacki, Milwaukee	o	o	o
	S. E. Zawodny, Milwaukee	x	x	x
	P. J. Niland, Milwaukee	x	o	x
	R. T. McCarty, Milwaukee	o	o	o
	A. G. Martin, Milwaukee	o	o	o
	A. J. Sanfelippo, Milwaukee	o	x	x
	D. M. Willson, Milwaukee	x	x	x
	M. C. F. Lindert, Milwaukee	o	o	o

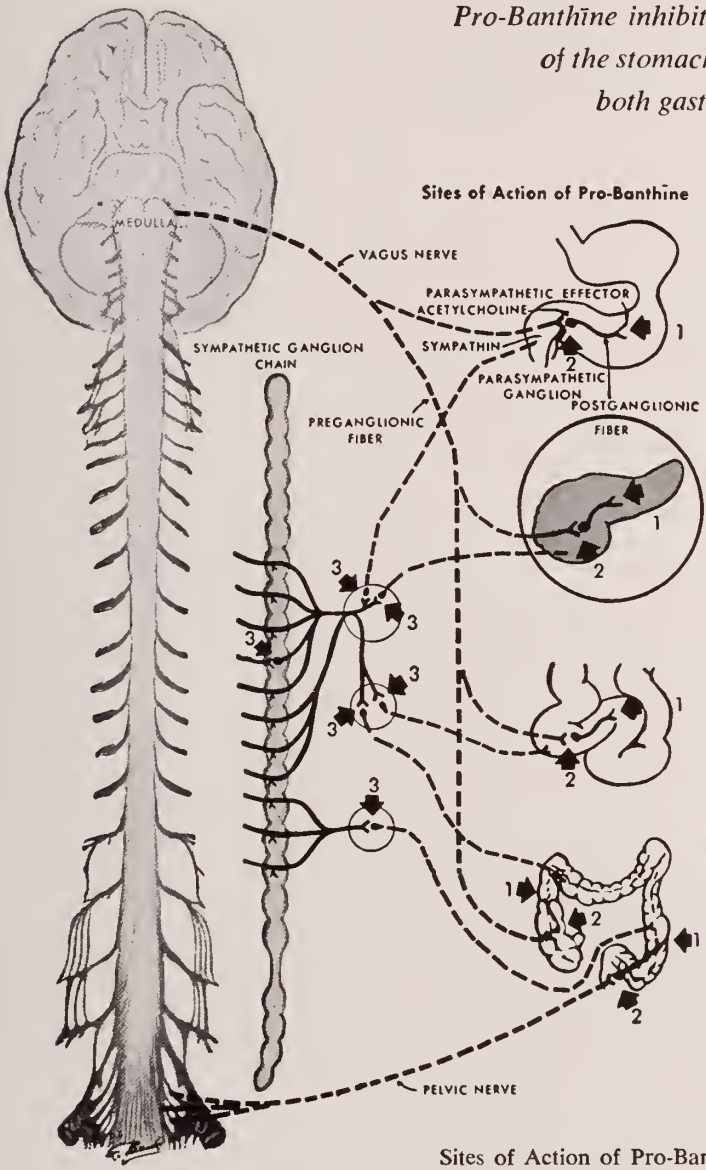
* Indented names are those of alternates.

(Continued on page 906)

PROVED ANTICHOLINERGIC EFFICIENCY

Pro-Banthīne® Provides Rapid Relief in Acute Pancreatitis

Pro-Banthīne inhibits excessive vagal stimulation of the stomach and pancreas and reduces[1,2] both gastric and pancreatic secretions.



With use of the Levin tube and a drug "such as Pro-Banthīne . . . most cases of acute pancreatitis[3] will subside in a few hours, or at the most, in a few days."

Schwartz and Hinton achieved[4] dramatic relief of pain in four of six patients with acute hemorrhagic or edematous pancreatitis within twenty to thirty minutes after giving Pro-Banthīne intramuscularly. A dose of 15 to 30 mg. may be repeated[1] parenterally at intervals of six hours.

Pro-Banthīne bromide (brand of propantheline bromide) also has proved highly effective in the therapy of peptic ulcer, hypertrophic gastritis, diverticulitis, biliary dyskinesia, ileostomies and genitourinary spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Jones, C. A.: Arch. Int. Med. *96*:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. *15*: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America *38*:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

Sites of Action of Pro-Banthīne. *The principal site of action of Pro-Banthīne is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).*

SEARLE

(Continued from page 904)

Society	Physicians*	Sessions 1	2	3
	John Beffel, Milwaukee	x	o	x
	C. M. Schroeder, Milwaukee	o	o	o
	S. A. Morton, Milwaukee	x	x	x
	E. M. End, Milwaukee	x	o	x
	I. J. Ricciardi, Milwaukee	x	x	o
	J. F. Cary, Milwaukee	o	o	o
	F. E. Drew, Milwaukee	x	x	x
	E. G. Collins, Milwaukee	x	o	o
	W. J. Houghton, Milwaukee	x	x	x
	R. H. Lillie, Milwaukee	o	o	o
	G. W. Hilliard, Milwaukee	x	x	x
	R. A. Nimz, Milwaukee	o	o	o
	E. R. Daniels, Milwaukee	x	x	o
	Owen Royce, Milwaukee	o	o	o
	M. S. Fox, Milwaukee	x	x	o
	F. J. Krueger, Milwaukee	o	o	o
	J. E. Conley, Milwaukee	x	o	x
	S. M. Feld, Milwaukee	o	x	o
	H. J. Lee, Milwaukee	o	o	o
	G. C. Owen, Milwaukee	o	o	o
	G. E. Collentine, Jr., Milwaukee	x	x	o
	T. R. Murphy, Milwaukee	o	o	o
	Joseph Shaiken, Milwaukee	x	x	o
	D. S. Thatcher, Milwaukee	o	o	o
	H. P. Maxwell, Milwaukee	o	o	o
	W. A. Brah, Milwaukee	o	o	o
	J. W. Fons, Milwaukee	x	x	x
Monroe	D. C. Beebe, Sparta	x	o	o
	Judson Allen, Norwalk	o	o	o
Oconto	H. A. Aageson, Oconto	x	x	x
	Gilbert Sandgren, Suring	o	o	o
Oneida–Vilas	Marvin Wright, Rhinelander	x	x	o
	I. E. Schiek, Sr., Rhinelander	o	o	o
Outagamie	G. W. Carlson, Appleton	x	x	x
	H. T. Gross, Appleton	x	x	x
Pierce–St. Croix	P. H. Gutzler, River Falls	x	x	x
	O. H. Epley, New Richmond	o	o	o
	C. A. Olson, Baldwin	o	x	x
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery	o	o	o
Portage	F. E. Gehin, Stevens Point	x	x	x
	R. H. Slater, Stevens Point	o	o	o
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	W. E. Niebauer, Phillips	o	o	o
Racine	K. W. Covell, Racine	x	x	x
	F. J. Scheible, Racine	o	o	o
	R. W. Kreul, Racine	x	x	x
	Grace E. Schenkenberg, Racine	o	o	o
Richland	D. J. Taft, Richland Center	o	x	x
	R. E. Housner, Richland Center	o	o	o
Rock	H. E. Kasten, Beloit	x	x	x
	W. S. Freeman, Beloit	x	o	x
	M. D. Davis, Milton	o	x	x
	J. D. Schroeder, Janesville	x	o	o
Rusk	H. F. Pagel, Ladysmith	x	x	x
	J. E. Murphy, Ladysmith	o	o	o
Sauk	B. E. McGonigle, Baraboo	x	o	x
	C. R. Pearson, Baraboo	x	x	x
Shawano	H. C. Marsh, Shawano	x	x	x
	Donald Jeffries, Shawano	x	o	x
Sheboygan	P. B. Mason, Sheboygan	x	x	o
	F. A. Nause, Sheboygan	o	o	o
Trempealeau–Jackson–Buffalo	B. C. Dockendorff, Arcadia	x	x	x
	D. S. Sharp, Mondovi	o	o	o
Vernon	R. S. Hirsch, Viroqua	x	x	x
	F. F. Gallin, La Farge	o	o	o
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	E. D. Hudson, Lake Geneva	o	o	o
Washington–Ozaukee	E. C. Quackenbush, Hartford	x	o	x
	P. B. Blanchard, Cedarburg	o	o	o
Waukesha	Joseph Bartos, Waukesha	x	x	x
	James Bolger, Waukesha	x	x	o
Waupaca	Marshall Boudry, Waupaca	x	o	o
	William McInnis, Marion	o	o	o
Winnebago	George Schwei, Menasha	x	x	x
	David Regan, Neenah	o	x	x
	W. V. Hahn, Oshkosh	o	x	x
	R. F. Wagner, Oshkosh	x	o	o
Wood	R. W. Mason, Marshfield	x	x	x
	H. G. Pomainville, Wisconsin Rapids	x	o	o
General Practice	C. A. Fosmark, Madison	x	x	x
	George Benish, Madison	o	o	o
Internal Medicine	R. N. Allin, Madison	x	o	o
	Louis Kurten, Racine	x	x	x
Neurology and Psychiatry	Harry Tabachnick, Milwaukee	x	o	o
	E. Madison Paine, Green Bay	x	o	o
Obstetrics and Gynecology	F. J. Hofmeister, Milwaukee	o	o	o
	W. O. Paulson, Eau Claire	o	o	o
Ophthalmology and Otolaryngology	E. J. Zeiss, Appleton	o	o	x
	H. C. High, Jr., Milwaukee	x	x	o
Orthopedics	D. W. McCormick, Fond du Lac	o	o	o
	F. G. Gaenslen, Milwaukee	o	o	o
Pathology	Gorton Ritchie, Milwaukee	x	x	x
	R. S. Haukohl, Milwaukee	o	o	o
Pediatrics	G. H. Wegmann, Milwaukee	x	x	o
	Kenneth Winters, Wauwatosa	o	o	x
Public Health	C. K. Kincaid, Madison	o	o	o
Radiology	W. T. Clark, Janesville	x	x	x
	R. L. Troup, Green Bay	o	o	o
Surgery	J. M. Sullivan, Milwaukee	o	o	o
	M. G. Rice, Stevens Point	o	o	o
Urology	J. W. Sargent, Milwaukee	x	o	o
	R. S. Irwin, Milwaukee	o	x	x

* Indented names are those of alternates.

THE MEDICAL FORUM

CIRCUIT PROGRAMS TO PRESENT CLINICAL CASES

MADISON—The Council on Scientific Work is pleased to announce a new four-month schedule of circuit teaching programs for the current academic year, which will stress case material and use of patients when appropriate to the subjects covered by the faculty.

These programs, which have served around 600 to 700 physician members annually, are presented as joint efforts of the State Medical Society, the two medical schools in Wisconsin, the State Board of Health, the Wisconsin Academy of General Practice, the Wisconsin Heart Association, the Cancer Society and W.A.T.A.

PROGRAMS TO VARY

The format of the program will vary, depending upon the amount of clinical material available for discussion during the afternoon. The evening program will be correlated with the afternoon session, and on several occasions include one specific talk on a subject of general interest.

The registration fee will include dinner, and all those attending the afternoon session are urged to participate in the evening program as well, as there will be no refund given to those who attend just a portion of the program.

The programs have been reviewed by the regional representatives of the American Academy of General Practice and have been certified for 4 hours of Category I (Formal Teaching) Credit. Registration cards will be furnished Wisconsin Academy members at each meeting.

SIGN UP NOW!

Because dinner arrangements must be made for each teaching program, you are asked to kindly make reservations in advance. Use the reservation slip provided on page 840 and make your covering check payable to the State Medical Society of Wisconsin.

Dr. Epperson

Dr. Epperson Named Region I Med Director for Civil Defense

MADISON—Dr. E. P. Epperson, of Watertown, has been named medical director of Region I, Wisconsin Civil Defense.

The appointment was made by Dr. Carl N. Neupert, State Health Officer, in cooperation with the State Medical Society's Committee on Civil Defense.

Region I includes Dodge, Fond du Lac, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Sheboygan and Waukesha counties.

Seek To Pool Resources in Health Insurance

WASHINGTON—A bill permitting non-profit associations such as Blue Cross and Blue Shield and smaller health insurance companies to pool resources in developing improved coverage has been sent to Congress by the U. S. Dept. of Health, Education and Welfare.

Such authority, if granted by Congress, would cover all but 20 firms among the 1,100 in the field. Anti-trust regulations now restrict pooling arrangements.

The measure cites four areas where additional progress is particularly needed: protection against severe or costly illness, and coverage for older persons, for those in rural areas and for persons with physical impairments.

ON THE S.M.S. CALENDAR . . .

AUGUST

16—Council on Scientific Work, Milwaukee.
21—10th District Organization Meeting, SMS.
22–24—National Blue Cross-Blue Shield Public Relations Conference, Madison.
29–30—A.M.A. Public Relations Conference, Chicago.

SEPTEMBER

4—Claims Committee, SMS.
7–9—Commission on Prepaid Plans and General Council, Manitowish.
11—Circuit Program, St. Francis Hospital, La Crosse.
12—Circuit Program, Sacred Heart Hospital, Eau Claire.
13—Circuit Program, St. Mary's Hospital, Superior.
16–18—Wisconsin Chapter, American Academy of General Practice, Milwaukee.
21—Basic Science Board Examinations, Madison.
22–23—Clinic Managers, Madison.

OCTOBER

2—Claims Committee, SMS.
9—Circuit Program, Bellin Hospital, Green Bay
10—Wisconsin Commission for Improvement of Patient Care, Milwaukee.
10—Circuit Program, St. Joseph's-Lloyd Hospital, Menominee, Mich.
11—Circuit Program, St. Mary's Hospital, Wausau.
18—Conference on School Health, Whitewater.
22—Blue Cross-Blue Shield Workshop Conference, Chicago.

NOVEMBER

15—Conference on School Health, Superior.

HEAR INC. AIDS PHYSICIANS ON HEARING PROBLEMS

Agency Works to Assist Deaf and Hard-of-Hearing

MADISON—Hear Incorporated is a non-profit public service agency operating in Madison to assist the deaf and hard-of-hearing. Its help, however, is not limited to Madison. It extends its facilities to any person in Wisconsin.

Its objectives, like those of the American Hearing Society of which it is a member, are: **prevention of deafness, conservation of hearing, rehabilitation of hard of hearing, and public education.**

The physician members of its board of directors include Drs. James F. Land, Charles R. Taborsky, Horace K. Tenney III, and C. K. Kincaid, all of Madison.

GOOD LEADERSHIP

Its director is Mrs. Janice D. Stovall, Madison, who has had experience and training in speech and hearing and in public health education. It also employs a speech therapist who is a university graduate.

Hear Incorporated is established to:

1. Counsel any person or family in the problems of hearing.

2. Aid the physician by doing hearing testing he deems necessary, but for which he does not have the equipment or trained personnel. A report is forwarded to the physician.

3. Test persons that question the acuity of their hearing and make recommendation that they see their physician if they are found to have a hearing loss. If the loss cannot be corrected medically, Hear Inc. advises them to return for help.

4. Loan hearing aids to deserving persons.

VARIED AID

5. Aid the hard-of-hearing person that can benefit from a hearing aid by—

a. Discovering the extent of the hearing loss.

b. Helping him to learn to make the best use of his aid.

c. Offering classes or individual training in auditory training, speech reading and speech correction.

6. Aid the hard-of-hearing person that cannot benefit from an aid by discovering the extent of his hearing loss and helping him with lip reading, speech correction, and auditory training.

7. Assure summer instruction for deaf children.

8. Educate the public to the problems of the hard-of-hearing as well as making the public aware of what could and should be done in case of a hearing problem.

TO EXPAND

9. Act as a coordinating agency by directing persons to the proper community service for assistance.

During the past year, exclusive of National Hearing Week, Hear Inc. has counseled and offered help to 486 persons. With the additional new testing equipment, it will be able to offer a more complete testing program.

SEE YOUR M.D.!

During National Hearing Week, adult hearing testing demonstration centers in Madison and Dane County tested 411 persons, making a total of 897 assisted during the year. Of the 411, there were 143 persons found to have a severe hearing loss. Each person that had not consulted his physician was asked to do so to determine whether the loss could be corrected medically.

This program of testing and rehabilitation is not an overlap of any other service in the community. There is no other program offered to adults in the Madison area, and none in Wisconsin other than the city of Milwaukee. Children, of course, are helped through the Department of Handicapped Children, Departments of Health and the Public Schools.

A number of hearing aid dealers are thoroughly conscientious, using the audiometer for testing, and making every effort to see that the aids they sell do a good job of correction. Unfortunately, there are others who fit merely by guesswork and are more interested in making a sale than fitting the patient correctly. None offer auditory training or speech reading as part of the rehabilitation program.

The physician often finds it impossible because of a local situation to recommend for his patients beyond medical advice. He realizes at the same time that if his patient buys a hearing aid by consulting the classified section of the phone book, he might or might not purchase the best aid for his need. Hear Inc. can help the physician in such a dilemma by testing and informing him of the type of loss and the amount of gain the patient can tolerate, so that he will be able to advise his patient.

The patient will usually become a more satisfied user and experience less emotional disturbance if he receives auditory training and speech reading. The physician can help his patient by knowing such a service is available and advising his patient.

It is the belief of Hear Inc. that by close cooperation among itself, the patient, physician, and the hearing aid dealer, the person who accepts impaired hearing as an incurable evil can become a rarity.

Hear Inc. is located at 303 State St., Madison.

BC–BS Public Relations Conference at U.W.

MADISON—The public relations conference for Blue Cross and Blue Shield plans will be held on the University of Wisconsin campus **Aug. 22–24.**

The program was organized with the cooperation of the University's departments of commerce and adult education.

Persons attending the sessions will be awarded certificates of accomplishment by the University. Lectures and discussion seminars are expected to provide ample opportunity to appraise special problems and projects.

DR. L. O. SIMENSTAD, president of the State Medical Society of Wisconsin, was honored by his townspeople in Osceola June 23. A physician in that community for 32 years, Dr. Simenstad (center) has been mayor for the past 10 years. He is shown above being presented a desk set by Robert Paulson, president of the Osceola Civic and Commerce Association. Mrs. Simenstad was a proud wife at the proceedings.—(St. Paul Pioneer Press Photo)

Dr. L. O. Simenstad Honored at Osceola

OSCEOLA, WIS.—The home folks of this Polk County village and others gathered in June to pay tribute to one of their favorite friends, **Dr. L. O. Simenstad.**

The newly-installed president of the State Medical Society, in his 32nd year of practice in this community, was tendered a testimonial dinner and praised as an *"upright citizen, one who kept up to date and a man who has done much for his fellowmen."*

Dr. Simenstad, mayor of Osceola since 1946, was instrumental in obtaining a new interstate bridge across the St. Croix River at Osceola, and is a member of the Wisconsin State Aeronautics Commission, currently serving as vice chairman.

ACTIVE CITIZEN

He is chief of staff of the Ladd Memorial Hospital, and did much to secure Hill-Burton funds for a recent addition. Dr. Simenstad also was cited for bringing an aircraft manufacturing firm to Osceola.

Principal speakers at the dinner included **Dr. V. C. Kremser,** of Amery, representing the Polk County Medical Society; **Dr. R. H. Wilson,** Winona, president of the Minnesota Medical Society; **Dr. W. H. Hengstler,** St. Paul; **C. H. Crownhart,** Madison, secretary of the State Medical Society of Wisconsin, and **Robert Paulson,** president of the Osceola Civic and Commerce Association.

OK New Expense Deduction Plan For Physicians

WASHINGTON—A new regulation, effective Aug. 9, now permits physicians to deduct their expenditures in taking postgraduate refresher courses.

Issued by the U. S. Internal Revenue Service, the regulation followed a long-time effort by the A.M.A. Law Department to effect such a ruling.

The regulation provides that expenditures for education are deductible from personal income tax returns if they are for a refresher or similar type of course taken to *maintain*—but not to acquire—the skills directly and immediately required by a physician in his employment or business.

NO ACADEMIC CREDIT

To be covered, an educational course must be designed for established and medical practitioners to help them keep abreast of current developments in the profession. It should be of short duration, taken on a continuing basis and *not carry academic credit.*

Education designed to prepare a practictioner to enter a specialty will not be acceptable.

When a physician travels away from home primarily to obtain refresher education, his expenses for meals, travel and lodging are deductible. Expenditures for personal activities, or for such members of his family who may accompany him, will not be allowed for deduction purposes.

Rename Dr. Gavin Head of State Board Of Health

MADISON—Dr. Stephen E. Gavin, Fond du Lac, has been re-elected president of the Wisconsin State Board of Health.

A member of the Board for 13 years, Dr. Gavin, a past-president of the State Medical Society, has been its head for nine years.

Dr. Samuel Henke, Eau Claire, was re-elected vice president of the Board, thus retaining a post he has held since 1948.

The following physicians were reappointed to the advisory hospital council:

Drs. Harold Coon, Milwaukee and H. A. Sincock, Superior.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE policies are not terminated nor are benefits reduced because of age.

T.I.C.

TIME INSURANCE COMPANY

MILWAUKEE WISCONSIN

A FORUM FEATURE . . .

CORPORATE EXECUTOR RECOMMENDED IN EXECUTING WILL

If Estate Is Large Or Complicated, Seek Assistance

MADISON—Be wise—when the time comes to name someone to execute your will—pick a corporate executor, **not** your wife.

Any attorney will tell you that the collective and group judgment available through the services of a corporate executor—the trust department of a bank—is of great importance, and surpasses any other source.

A widow, for example, serving as executrix of her husband's estate, could hardly be expected to make major decisions with the same degree of competence as could the qualified officers of a bank. *This is particularly true if the estate is a large one, or is complicated, or the widow is aged.*

CHOICE IMPORTANT

An older doctor of medicine who picks a bank as executor of his possessions assures himself of top judgment with respect to all essential decisions made in the administration of his estate. There are exceptions, of course, and this matter depends upon existing circumstances.

Most always, a father who is head of a family names his wife or adult son or daughter as executor of his will. Of these close family members, the wife is probably the least qualified to carry the burden of estate administration. Yet, she is the one the deceased family head would ordinarily want to receive most of the benefit of any saving in cost.

Check your experience, your own friends, and you'll find this is the way it is usually handled.

NOT OPPORTUNE

The wife thusly must serve as executrix at a time when she has suffered the loss of a loved one, and this is an inopportune time for her to take on a serious responsibility. Then, too, for a wife to "save" what might otherwise go to a corporate executor, she must perform a service and take on a burden for which she undoubtedly is poorly prepared.

THINGS TO REMEMBER!

In addition to the points brought out in this Forum article re executing wills, check your status on the following:

- ★ Have you made sure your will was properly signed, dated and witnessed?
- ★ Did you dispose properly of your personal effects in the document?
- ★ Did you include your life insurance proceeds?
- ★ Do you check the will periodically? Changes may be in order.
- ★ Has your wife made out a will, too, as she should?
- ★ Is your will foolproof?

There was a downstate doctor who named his wife as executrix. When it came time to handle and read his will, she was in a mental hospital. The couple was childless. No alternate executor had been named, and the court selected one.

Several legal battles ensued when it was learned the physician's will had not been properly witnessed. It's altogether possible that final disposition of the estate, because a number of in-laws and distance cousins entered the picture, was far afield from his original intent.

REFEREE NEEDED

Relatives remain split and in a feuding spirit, friends reported, because the estate was of considerable size. Perhaps the executor could have waylaid the court fight; at least he would have been in a position to act as moderator. Another thing—immediately after his appointment he would have checked on the validity of the will, and noted the improper witnessing.

Sometimes a son or daughter is chosen executor. The widow, of course, receives no compensation. And actually, there would be no saving in administration costs insofar as she is concerned . . . in the long run.

WHY CHANGE?

How many times during the lifetime of a husband does he turn over to his wife every responsibility which he has been carrying? How many times does he say she should have all final say-sos on estate affairs? And that he plans to confer and consult with her on all decisions?

Yet—that is what a husband does when he names his wife sole executor of his estate!

AVOID TROUBLE

Another objection to naming any member of the family to do this job is the very real danger of misunderstandings developing between one family member selected and other surviving heirs.

You've heard of frequent family squabbles over the handling of a will and disposition of an estate...

There is a report of a large family group in eastern Wisconsin currently arguing over the extensive holdings of a woman who is still living. She is not in the best of health, is becoming senile, but may live on for 10 or more years. She never married, and her sisters and brothers, and their children, are no longer speaking to each other.

SORRY SITUATION

Who's handling the will? The husband of one of her nieces, and feel pity for the poor fellow. This mess could have been averted by giving the task of handling the estate to a corporate executor who would have taken care of the details in due time.

Surely, a corporate executor generally is in a better position to be impartial, unbiased and firm when necessary, than is a member-of-family executor. The compensation of a corporate executor will seem small, indeed, if the services rendered avoid family disputes and hard feeling which otherwise often develop.

There are other factors, too, in considering the choice between a family or corporate executor.

(Continued on page 914)

Medical Examiners Crack Down on Herb Peddler

DARLINGTON—Elzy Young, Darlington, an herb peddler, was fined $700 and costs in Lafayette County court recently on two charges of practicing medicine without a license.

The Wisconsin State Board of Medical Examiners obtained conviction in the case, following extensive investigational work.

Young, who pleaded guilty to the charges, originally was arraigned on four counts of violating the Medical Practice Act, Sections 147.02 and 147.14.

SENTENCE SUSPENDED

A two-year sentence in the county jail was suspended by Judge Joseph F. Collins.

Young was selling herbs door-to-door at $25 a jar. The jars contained plant fragments identified as various grasses, mint and members of the fig wart family.

More Than 7,000 Join Arthritis, Rheumatism Drive

MILWAUKEE—More than 7,000 Wisconsin residents registered in the first statewide arthritis registration campaign conducted by the Wisconsin Chapter of the Arthritis and Rheumatism Foundation this year.

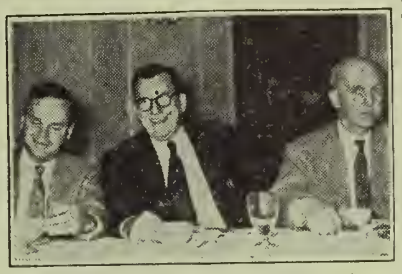
All registrants received current information on the two diseases. The Foundation plans to utilize information relative to the registration to plan meetings and seminars in areas where concentration of sufferers is heaviest.

NAME OFFICERS

Mrs. J. Martin Klotsche, Milwaukee, was re-elected Foundation president.

Dr. Edwin C. Welsh, Wauwatosa, was elected to a three-year term on the board of directors. Other directors include *Drs. Millard Tufts*, Whitefish Bay; *J. F. Wyman*, Milwaukee; *A. W. Bryan*, Madison; *Milton Borman*, River Hills; *William J. Egan*, Milwaukee; *Mark W. Garry*, Wood and *John Schindler* of Monroe.

The campaign was supported by the State Medical Society.



CONTRASTS—Dr. P. B. Mason (center) of Sheboygan, enjoyed the story most of all. Dr. A. W. Hilker (left), Eau Claire, apparently had heard it before. Dr. K. H. Doege of Marshfield, didn't listen. The three physicians recently attended a meeting of the Commission on Prepaid Plans.

Medical Assistants Outline Projects

MADISON—Four officers of the Wisconsin Medical Assistants Society came before the Council on Medical Service July 15 to tell of their plans and problems.

Lois Pluckhan, Madison, Society president, explained that initial efforts to develop a placement program for assistants were not progressing favorably, and asked for views relating to a pilot project.

Miss Pluckhan; Audrey Holtshopple, Janesville, president-elect; Peggy Clark, Madison, corresponding secretary and Esther Bittrich, Beloit, public relations chairman, also said a recognized training program for would-be assistants is a great need, and that the officers were also concerned about enlarging the organization's membership.

Dr. J. S. Devitt, Milwaukee, Council chairman, said he was confident a training program could be worked out in the colleges or vocational schools of the state, and pledged the support of the Council

The assistants were advised to utilize various publications to get their story before the physicians and possible members.

Groups Work To Improve Licensing Regulations

MILWAUKEE—To improve liaison between the Committee on Public Policy and the State Board of Medical Examiners, members of the two groups met in Milwaukee, July 12.

One of the subjects discussed was licensing of foreign medical school graduates to practice in Wisconsin. An interim procedure for licensing the physicians until development of a national program was considered. The AMA House of Delegates adopted a report last June which may lead to certification of foreign graduates by a national agency.

Discussion also centered around a method of gross screening of all applicants and the possibility of legislation to coincide with the development of the national agency handling foreign school graduates.

Legislative plans relating to the State Medical Society's investigation of cult practices in Wisconsin were brought before the two groups. Preliminary findings indicated the cult proposals would substantially expand existing limitations upon the practice of chiropractors and other cultists.

Dr. T. W. Tormey, Jr., Madison, Board secretary, said an increase in the number of physicians holding temporary educational permits, now set at 25, would not be unjustified. He said the Board is besieged with applicants for permits and requests from hospitals in the state for expansion of the program.

The concensus of those present was that the Board should be permitted to approve a maximum of 50 annually. Before becoming effective, the law regulating this practice would have to be changed in the Wisconsin legislature.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

HALO . . .

Another in a series of apt cartoons from a publication entitled IS YOUR HALO ON STRAIGHT is shown below. The HALO series was published for the Ethics and Professional Conduct Council of the Alumni Association of the School of Medicine of the College of Medical Evangelists by San Lucas Press, Los Angeles. It has been described as a "sharp public relations idea, with rapier-like thrusts at physicians who know the shoe fits." HALO shows little fear of treading on toes.

The Showboat

This character makes us the fall guys for socializers.

Maybe he didn't get it all out of his patients.

Maybe he inherited it or married it.

But when he throws money around like he's shoveling it out of the Aga's can, there's only one source in his patients' minds.

Their pocketbooks.

They don't mind your earning a good living, provided it isn't too good too soon.

They figure you're entitled to a little show for your dough after long and faithful service.

By then you're too old to enjoy it.

So be subtle, son.

Blue Shield Membership Continues To Rise

MADISON—Wisconsin is one of 14 states having in excess of 20 per cent of its population with Blue Shield contracts.

With 780,000 persons under Wisconsin Physicians Service and Surgical Care, the state had 20.43 per cent of its population covered this spring.

Blue Shield Medical Care plans are now in operation in 42 of the 48 states, in the District of Columbia, in eight Canadian provinces and in the territories of Hawaii and Puerto Rico.

At the end of 1955, total membership in these areas was nearly 36 million members. This figure represents number of persons covered and not a contract count.

In 1946, total Blue Shield membership was less than two million persons.

Approximately $430,000,000 in premiums changed hands last year. Almost 84 per cent of this amount went back to the subscibers in the form of claim payments. Another 11 per cent was retained for operating costs.

More than 16,000 persons joined Blue Shield each working day in 1955. As a result, membership increased last year by 4,158,000.

Delaware leads the nation with more than 60 per cent of its population enrolled.

Continue Hospital–Physician Survey

MADISON—The Council on Medical Service and the Committee on Hospital Relations met July 15 to continue their joint study of hospital-physician relations.

The groups discussed the report of the *Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals*, as adopted by the AMA House of Delegates in Chicago, June 14, 1956.

The physicians present agreed it would be advisable to send information covering the House action to the chief of staff of each general hospital in Wisconsin, hospital administrators and secretary of each county medical society.

It was noted that the AMA's action is not binding upon the Joint Commission, an independent body comprised of representatives of physicians, hospitals and allied groups. The action is an instruction to AMA representatives on the Joint Commission to recommend those changes to the Commission.

The Council and Committee representatives are conducting a fact-finding inquiry of activities and developments in the field of accreditation and hospital-physician relations prior to making any recommendations.

Mendota Begins New Residency Program

MADISON—Mendota State Hospital has begun a residency program never before undertaken in a Wisconsin public mental institution.

Four medical school graduates recently started one-year residencies. The hospital was approved this spring for residency in psychiatry by the A.M.A. Council on Medical Education.

The four residents are **Dr. Richard Goodman**, Milwaukee, a graduate of the University of Wisconsin School of Medicine; and **Drs. John Koppa**, Rhinelander; **Robert Kraus** and **Bernard Bannen**, Milwaukee, Marquette University Medical School graduates.

ALSO ATTEND U.W.

They attend classes at Wisconsin on a part-time basis and have hospital patients assigned to them by the Mendota staff.

Dr. Adolph Soucek, assistant superintendent of Mendota, commented:

> *"The program is a continuation of their medical training—both theoretical and practical—with specialization in psychiatry. The program is part of the continuing emphasis on educational activity in state mental hospitals."*

This includes, he said, such things as psychiatric nurses training programs and another in which theological students work with the hospital chaplain in ministering to the patients' spiritual needs, all regarded as most successful.

"From a mental health aspect, in this program we're fulfilling a duty to the community by serving as a source of professional information," Dr. Soucek added. "We're bringing the hospital into closer relationship with the community.

TO FILL NEED

"By helping to produce full-fledged psychiatrists, there is a hope that as a by-product some of them may remain in Wisconsin, where there is a steady need for them in state hospitals."

The American Board of Psychiatry and Neurology requires that applicants to become psychiatrists must have three years of residency and two years of experience in a mental hospital beyond medical school before they qualify to take examinations.

Dr. Hollenbeck

Dr. Hollenbeck Named Vets' Society Treasurer

MILWAUKEE—Dr. Stanley W. Hollenbeck, Milwaukee, was elected treasurer of the National Medical Veterans' Society, taking office July 1.

World Med Group Invites Members

NEW YORK CITY—The satisfaction of sharing the advantages of American medical progress with other lands, and at the same time helping to protect the freedom of medicine is available to you.

The United States Committee Inc., of the World Medical Association, AMA-approved, is inviting physicians to join. Membership, the Committee said will bring you:

A share in representing the interests of the practicing physician before other international groups dealing with medicine.

Letters of introduction to foreign medical associations and their members, facilitating professional contacts when traveling abroad.

Certificate of membership, an introductory card to 700,000 doctors of nearly 60 nations joined in a world-wide movement for the highest possible level of medical service.

The World Medical Journal, published bi-monthly, and all published studies of WMA, with data nowhere else available on trends in world medicine.

The Association is the only world-wide non-governmental association dedicated to free enterprise in medicine.

Applications for membership may be sent to the *State Medical Society, P. O. Box 1109, Madison, Wisconsin,* or to Dr. Louis H. Bauer, of the U. S. Committee, WMA, 10 Columbus Circle, New York 19, N. Y.

Offer New Deferment Plan for Residents

MADISON—Dr. Frank L. Weston, Madison, chairman of the Wisconsin State Advisory Committee to Selective Service, has been advised of opportunities the armed forces will give to qualified physicians, subject to military service, who want residencies.

The director of Selective Service and the U. S. Dept. of Defense recently agreed to continue the *"Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program."*

POLICY OUTLINED

It will be the policy of the director of Selective Service to recommend the deferment of such registrants who may be selected by the Assistant Secretary of Defense for essential training under this program.

A maximum of 1,000 applicants will be approved for this program. They are asked to fill out and send *SD Form 249,* the statement of preference, to the Assistant Secretary of Defense, in the Pentagon, Washington 25, D.C., before Sept. 15.

REQUIREMENTS LISTED

In addition to being liable for two years of military service, applicants must be 1956 graduates of an accredited medical college in the United States or Canada, and be willing to accept a reserve commission in either the army, navy or air force.

Persons interested in additional information relative to the program are invited to write to the State Medical Society, Box 1109, Madison.

Dr. Woodruff Smith Visits S.M.S.

MADISON—A recent visitor to the State Medical Society headquarters in Madison was Dr. Woodruff Smith, of the Jones and Laughlin Steel Corp. medical department in Aliquippa, Pa.

Dr. Smith, a general practitioner in Ladysmith, Wis., from 1924 to 1954, also served as a member of the Wisconsin State Board of Health.

Listen to the "March of Medicine" on any one of 42 Wisconsin radio stations every week.

HONORED—Dr. H. O. Caswell, Fort Atkinson, (right) was cited for his many years of service by the Lions Club in his city recently. Making the presentation was Cal Langholff, chairman of the award committee.—(Daily Jefferson County Union Photo)

Fort Atkinson Honors Dr. H. O. Caswell

FORT ATKINSON—This city's "Man of the Year" is Dr. Harlow O. Caswell.

Honored at a recent testimonial dinner sponsored by the Fort Atkinson Lions Club, Dr. Caswell was described as a *"perfect doctor, but a poor collector, except in spiritual gifts."*

The physician, who was born in Fort Atkinson, retired from active medical practice in 1948, but has been serving as a volunteer resident M.D. at the Jefferson County Home and Hospital near Jefferson ever since.

Editorially, the Daily Jefferson County Union said:

"We've always thought Fort Atkinson was a mighty fine town, and now we've got proof positive.

"Dr. Caswell has funnelled just about all his attention into one channel . . . medicine. But what a great service he has done for his fellow citizens in that work! His has been a splendid combination of medical skill and a great kind heart."

Dr. Caswell termed the citation from his neighbors "a great honor."

Remember—you are welcome to visit the home of the State Medical Society of Wisconsin in Madison anytime!

EXECUTOR . . .

(Continued from page 910)

Generally speaking, the corporate counsel plan has continuous existence. Federal law provides for continuity of fiduciary service. An individual executor may die, move, become ill and infirm, or otherwise be unable to serve. The matter of continuous service is often problematical.

The bank offers continuous capacity through a succession of directors, officers and employes. The death or incapability of an individual executor forces the court to select a successor. But in a bank, there is wide choice of personnel ordinarily well qualified to assume responsibility. This is done usually without delay.

When deciding on a corporate executor, consider the financial status of the bank. Its trust department should be able to meet carefully prescribed state and federal capital requirements. It must secure the cash in estates and trusts with the pledge of securities as provided by statute. All assets held in the trust department must be kept segregated and rigidly safeguarded under dual vault control.

The safeguards of governmental supervision, too, should be a factor worthy of mention when selecting an executor. An individual, of course, is *not* subject to such supervision.

Any national bank is subject to examination by representatives of the Comptroller of the Currency, the Federal Reserve Bank and the Federal Deposit Insurance Corporation.

A state bank is subject to regulation by the state insurance commission.

That's protection!

Doctor!

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation Inc.?

AMEF REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation reported contributions recently from Dr. H. Kent Tenney, Madison, and the Brown–Kewaunee–Door County Medical Society.

Study Shows Insured Families Incur Higher Charges for Med Care

CHICAGO—A recent study showed insured families are admitted to hospitals more often, are more likely to undergo surgery and in turn incur higher charges for personal health services than families without insurance.

Dr. Odin W. Anderson, research director of the Health Information Foundation, presented highlights of his survey in *Hospitals*, journal of the American Hospital Association in July.

He stated:

"What was not anticipated was that insured families were more likely to utilize and incur higher charges for uninsured services, such as medicines and dental care, than were uninsured families.

"The average family with insurance incurred annual bills totaling $237 in 1953 for all personal health services, while the family without insurance incurred charges of $154."

The report indicated the average individual spends $65 and the average family $207 for health care each year.

Dr. Anderson said the provision of the health services is *"one of the biggest enterprises in the United States, totaling annually over 10 billion dollars for private care."* Of this amount, 3.8 billion dollars was paid to physicians and two billion to hospitals.

Approximately eight per cent of the families incurred no charges for health services during the year under study, while over 10 per cent paid charges of $500 or more.

"To All My Patients" Still Available

Madison—Copies of "To All My Patients," a public relations pamphlet published by the AMA, are available in the public information office of the State Medical Society.

The publication, handy pocket-sized and unusually readable and apt, was designed to familiarize the public with various aspects of medical care and cost.

Copies may be obtained by writing the Society, Box 1109, Madison. There is no charge.

Wives' Earnings Help 18% of Med Students Through School

CHICAGO—Most important sources of income for medical school students during the past year were vacation earnings, personal earnings during the school year, earnings of the student's wife, gifts from parents and the G.I. Bill.

Dr. Elmer Hess, Erie, Pa., immediate past-president of the A.M.A, quoting figures from a report of the *Association of American Medical Colleges*, said the information offered encouragement to those who would like to attend medical school.

VALUABLE CONTRIBUTION

Dr. Hess said that while he did not want to encourage students to take on the added responsibility of a family, it is a fact that the largest average income was wives' earnings. Eighteen per cent of the students reported that their wives' pay-checks, averaging $2,500 a year, were the largest source of income.

Ten per cent of the students said vacation earnings represented the largest source of income, while 40 per cent said it was gifts and loans, averaging $1,000, that helped put them through school. Eleven per cent said their parents supplied financial needs.

Other findings of the report:

Thirty-three per cent came from families in which the father was a laborer or in the lower levels of business.

VARIED PARENTAGE

Ten per cent were children of physicians. Sixteen per cent had fathers who were deceased, retired, unemployed or their occupations not indicated. Twenty-five per cent were children of executives or men in managerial positions, with the remainder in a middle-class grouping.

Of the nation's 81 approved medical schools, 72 offer scholarships and all 81 offer loans to upperclassmen. Forty-three offer scholarships and 59 offer loans to freshmen.

Seventy-two of the schools permit freshmen to work, and 78 allow upperclassmen to hold outside jobs.

Society Proceedings

Eau Claire–Dunn–Pepin

The regular monthly meeting of the Eau Claire–Dunn–Pepin County Medical Society was held May 28 at the Durand Rod and Gun Club in Durand.

Dr. W. E. Johnson, Jr., of Rochester addressed the meeting on "Surgical Treatment of Diabetic Complications." Doctor Johnson is head of the section on orthopedic surgery at the Mayo Clinic.

After the business session a dinner was served to society members and members of the woman's auxiliary, who met with the physicians. This was the final meeting of the society for the current season.

Polk

The Polk County Medical Society met June 21 at the home of *Dr. Stella Burdette* at Balsam Lake.

During the business session it was decided that the next meeting, to be held July 12, be devoted to discussion of a cancer detection survey.

A picnic supper served by the woman's auxiliary followed the meeting.

Dr. W. D. Stovall, Madison, discussed cancer detection programs at the July 12 meeting of the society, and the group voted to sponsor such a program starting August 1. Fifteen members were present at the dinner meeting held at the Anchor Inn, Siren, where the physicians were guests of *Dr. David Maas*, Webster.

Richland

Twelve members of the Richland County Medical Society met May 3 at the Richland Hospital Library in Richland Center.

Dr. S. B. Crepea, Madison, was the guest speaker and chose as his topic "Steroids in the Symptomatic Treatment of Allergies."

Winnebago

A social meeting of the Winnebago County Medical Society was held June 21 at the Elks Club, Menasha. The event was planned under the direction of *Dr. Donald Ryan*, Neenah, program chairman. A short business meeting was held.

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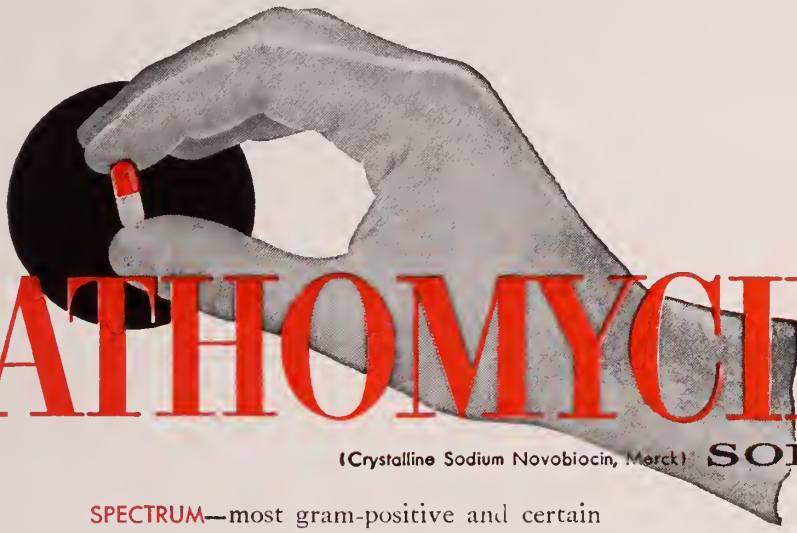

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News Items and Personals

Doctor Olson Speaks in Chicago

Dr. Marvin Olson, Wittenberg, spoke on June 13 before the first meeting of the United States Committee of the World Medical Association which was held in Chicago.

Doctor Olson, who attended the ninth general assembly of the World Medical Association last September in Vienna, Austria, spoke on the importance of the World Medical Association in American medicine.

Doctor Horswill Joins University Hospitals Resident Staff

Dr. C. Weir Horswill, Black River Falls, has recently located in Madison, where he will join the resident staff of the department of obstetrics and gynecology at University Hospitals.

Following his residency, Doctor Horswill plans to remain in Madison, engaging in the practice of obstetrics and gynecology.

Symposium Held at Green Bay

Physicians from Wisconsin and surrounding areas attended a symposium conducted by the Wisconsin Chapter of the American Academy of General Practice and the Lederle Laboratories Division of the American Cyanamid Company on June 28 in Green Bay. Topics discussed included smoking vs lung cancer, modern anesthetics, skin banks, fracture treatment, and obstetrical practices. Among the specialists appearing on the program were members of the medical school faculties of the University of Wisconsin, Marquette University, Washington University of St. Louis, Louisiana State University, the University of Texas, and the University of Chicago.

Doctor Springer Locates in Florida

Dr. Joseph Springer, who had been associated with his brother, *Dr. Frank Springer*, at the Springer Clinic, Elmwood, since 1951, has moved to Tampa, Florida, where he has accepted a position with the public health department. His duties at the new post began on July 1.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Doctor Simenstad Honored

A testimonial dinner honoring *Dr. L. O. Simenstad*, Osceola, was held June 23 at the Osceola High School auditorium. About 150 friends of Dr. and Mrs. Simenstad attended to pay tribute to Dr. Simenstad for his 32 years of medical practice.

Doctor Schroeder Named to American Board of Pediatrics

Dr. Robert W. Schroeder, Fond du Lac, was recently appointed to the American Board of Pediatrics.

Prior to locating in Fond du Lac, Doctor Schroeder was chief resident at Milwaukee Children's Hospital, Milwaukee, and also was assistant clinical instructor in pediatrics at the Marquette University School of Medicine.

Doctor Conklin Accepts Fellowship

Dr. J. W. Conklin, Platteville, has announced his retirement from the practice of general medicine in Platteville.

He plans to locate in New Orleans, where he has accepted a fellowship in radiology at Charity Hospital of Louisiana.

Neenah City Physician Retires

Dr. M. N. Pitz, Neenah's city physician for 25 years, recently resigned the post because of illness. The city council voted him a certificate of commendation for his long and devoted service to the city.

Doctor Osborne Joins Doege Medical Center

Dr. John V. Osborne was recently appointed to the medical staff of the Doege Clinic located in Marshfield.

Doctor Osborne is a graduate of the University of Illinois Medical School and interned at the U. S. Marine Hospital on Staten Island, N. Y. He served in the U. S. Public Health Service in Miami, Florida; on the surgical service staffs of the U. S. Marine hospitals in Norfolk, Virginia, and in Boston; and as assistant chief of surgical services at Native Hospital in Anchorage, Alaska. While in Boston he also was an instructor in human anatomy at Tufts Medical School.

Doctor Wright Named Chairman of Heart Group

Dr. Robert S. Wright, Racine, was appointed district chairman for the newly created Southeast District Heart Committee at a meeting of the board

of directors of the Wisconsin Heart Association held recently in Milwaukee. The district will include Kenosha, Racine, Walworth, and Waukesha counties.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Whitsitt Joins Madison Physicians

Dr. R. E. Whitsitt has recently become associated with *Drs. H. M. Carter, T. A. Leonard,* and *W. V. Luetke.* Having just completed his residency at University Hospitals, Madison, in obstetrics and gynecology, he will specialize in that field.

Doctor Kasak Addresses Meeting

Dr. Michael Kasak, retired medical director of the Milwaukee County Hospital for Mental Diseases, spoke at the annual dinner meeting of the Milwaukee County Society for Mental Health on June 5. His topic was "The Problem of Mental Disease and How to Cope With It."

Milwaukee Doctor Participates in A.M.A. Scientific Exhibition

Dr. G. J. Gumerman, Milwaukee, was one of those who had charge of an exhibit on arthritis at the American Medical Association scientific exhibition at the June A.M.A. meeting. The exhibition was held at Navy Pier, Chicago.

Doctor Klein Certified By Internal Medicine Board

Dr. Morris Klein, Milwaukee, was recently notified of his certification by the American Board of Internal Medicine.

Doctor Brillman Appointed Medical Director

It was recently announced that *Dr. L. P. Brillman,* Beloit, has been appointed medical director of the Beloit Iron Works.

Doctor Reese Appointed Member of A.M.A. Council on Physical Medicine

Dr. H. H. Reese, Madison, has been appointed as a member of the A.M.A. Council on Physical Medicine, which held its first meeting in June at Chicago. Among the duties of members of this council are gathering and disseminating information which helps the medical profession in determining the therapeutic and diagnostic value of certain devices and methods used in physical medicine.

Doctor Reese recently resigned his position in the A.M.A. House of Delegates, where he had served as the representative from the Section on Nervous and Mental Diseases for a number of years.

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Neuropsychiatry Department of UW Medical School Divided Into Two Departments

The Department of Neuropsychiatry, University of Wisconsin Medical School, has recently been divided into two autonomous departments—Department of Neurology and Department of Psychiatry.

Dr. Hans H. Reese, former chairman of the Department of Neuropsychiatry, has been appointed as chairman of the Department of Neurology. As yet, no new chairman has been named for the Department of Psychiatry.

SOCIETY RECORDS

New Members

Hazel J. Trefts, 200 East Wells Street, Milwaukee.

Adeline B. Gauger, 610 North 19th Street, Milwaukee.

A. L. Gundersen, 1836 South Avenue, La Crosse.

W. S. Boutwell, 305 Court Street, Janesville.

W. P. Quigley, 650 South Central Avenue, Marshfield.

J. F. Zimmer, 2671 South 76th Street, Milwaukee.

M. F. Phillips, 5715 North Bay Ridge Avenue, Milwaukee.

J. C. Koch, 151 North Wisconsin Street, Berlin.

J. B. Davis, Markesan.

E. H. Ferguson, Monroe Clinic, Monroe.

T. A. Prier, 2669 North 92nd Street, Milwaukee.

H. M. Hillenbrand, 185 Hazel Street, Oshkosh.

Changes of Address

H. L. Kuhl, Wood, to 15860 Via Rivera, San Lorenzo, California.

T. W. Dorman,** Oscoda, Michigan, to 1700 North Main Street, Racine.

J. D. Spankus,** Seattle, Washington, to 4454th USAF Hospital, Ardmore AFB, Ardmore, Oklahoma.

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1. Braceland, F.J.: Texas State J. Med. 51:287 (June) 1955.
2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.

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J. E. Thompson, Mauston, to 1706 Jackson Street, La Crosse.

J. F. Riordan, Kaukauna, to 5000 West Chambers Street, Milwaukee.

J. C. Curry, Charlottesville, Virginia, to 1709 Division Street, Appleton.

E. A. Brucker, Milwaukee, to St. Mary's Hospital, Madison.

C. M. Strand, Milwaukee, to 2785 Pennsylvania Avenue, Dubuque, Iowa.

D. G. Ives, Ann Arbor, Michigan, to 8713 West Olive Street, Milwaukee.

Freddie N. Petersen, Lake Forest, Illinois, to Route 2, Box 17, Oconomowoc.

** Military Service

OBITUARIES

Dr. V. D. Crone, 84, died June 3 at the Beloit Hospital, Beloit, after being in poor health for several months.

Doctor Crone had been engaged in the specialty of eye, ear, and nose ailments in Beloit for three decades, locating there in 1918.

He was born in 1872 at Ipava, Illinois; received his medical education and degree at St. Louis University; and served his internship at Bellevue and Manhattan hospitals in New York City.

Doctor Crone was a member and past president of the Beloit Hospital staff and a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. At the Annual Meeting of the State Medical Society held in May, 1956, he was awarded membership in the Society's 50-year club.

Surviving are his wife; one daughter, Mrs. Charles E. Johnson of California; and a son, Dr. Richard D. Crone of Athens, Georgia.

Dr. W. O. Dehne, 61 years of age, died June 4 after a three-month illness.

Doctor Dehne was born in 1894 in Hustisford. In 1921 he graduated from the Marquette University School of Medicine, and then interned at St. Elizabeth Hospital in Appleton.

He was a member and past president of the Outagamie County Medical Society and a member of the State Medical Society of Wisconsin and the American Medical Association.

Survivors include his wife; one daughter, Mrs. James Old of California; one stepdaughter, Miss Nancy Weiss, who lives at home; one son, James, of California; one brother; and five sisters.

Dr. O. V. Overton, who had practiced medicine in Janesville since 1923, died unexpectedly on June 17 at his home. He was 58 years of age.

Doctor Overton was born in Turtle Township in 1897. He was graduated from the University of Wisconsin in 1920, and from Rush Medical College, Chicago, in 1922. He interned at University Hospitals in Madison before locating in Janesville.

He was a member and past president of the Rock County Medical Society; president of the Rock County Chapter, American Academy of General Practice; and a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his wife; one son, Dr. Richard S.; one daughter, Mrs. Don Clemetson; and five grandchildren.

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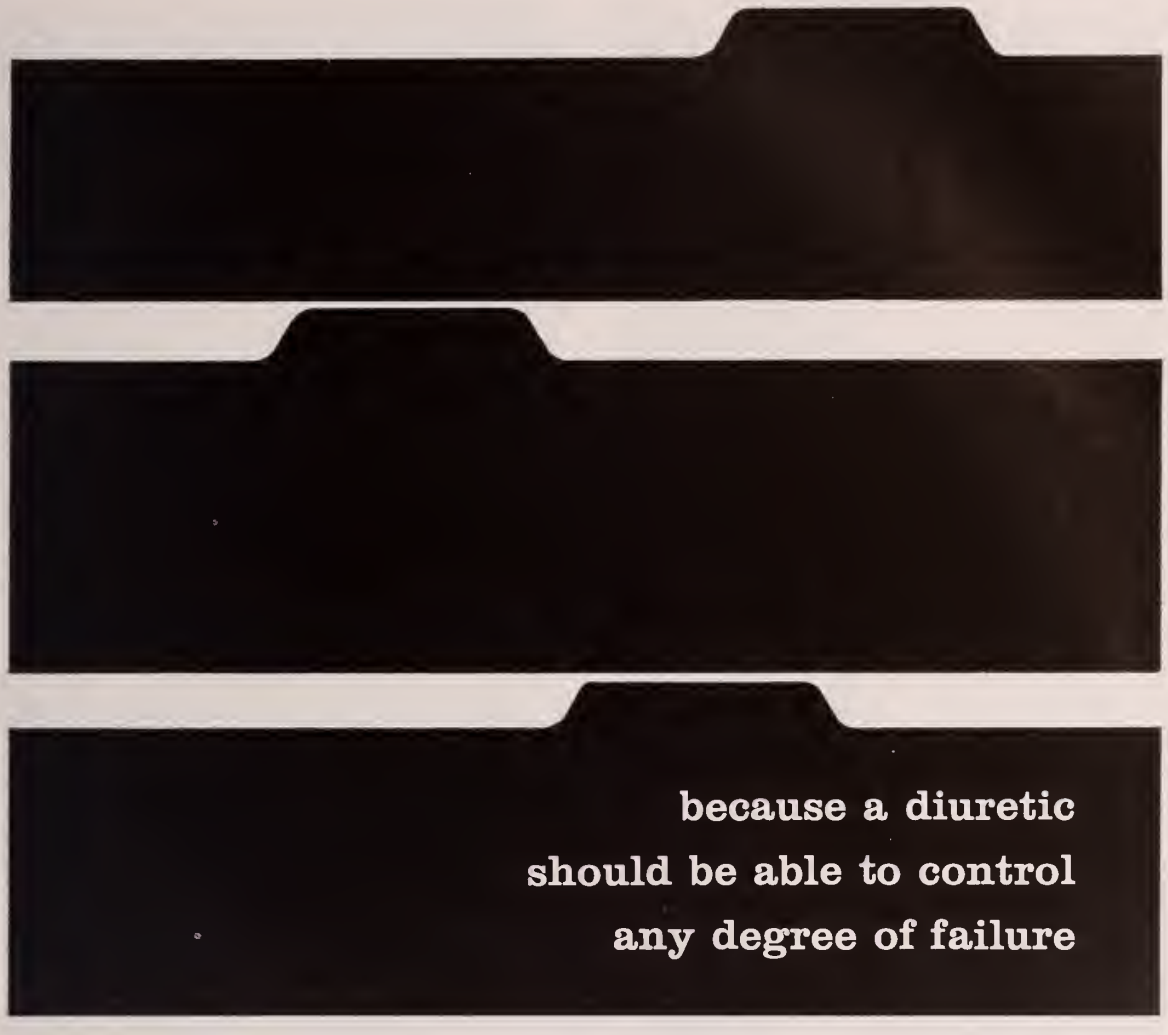

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Inescapable Duty

This is another in a series of reports on what other state medical societies are thinking in relation to health insurance programs. The excerpts reprinted below concern the report of the North Carolina Medical Society's Physicians Advisory Committee on Blue Shield, which recommended adoption of a two-level service benefit program with $4,000 and $6,000 income limits, a recommendation ultimately adopted:

"From experience with the State Compensation Commission and with insurance indemnity policies, doctors are understandably cautious and reluctant to assign to any third party their time-honored right to vary charges in accordance with the patient's means. They fail to concur in the social worker's enthusiasm to get every possible free service for a very nebulous group of 'medically indigent' families, using a highly elastic yardstick. Many of them are vociferous in their opposition to any clarification of the confusing muddle of professional fees for particular income levels. Without such clarification upon which to base costs, no insurance plan could undertake to pay unlimited professional fees, and the future satisfaction of the public for voluntary health insurance is limited in several states. Blue Shield offers one certificate with service benefits for the 'low income' group, comprising about 40 to 50 per cent of their population, and another certificate with higher professional fees as service benefits for 'intermediate income' families, comprising another 30 to 40 per cent of the population for whom the cost is reasonable and the plan successful.

"The top 20 to 25 per cent of the population will also find that such insurance is highly valuable, despite the fact that they are not entitled to service benefits and are liable for additional charges. In the far west, competition from Permanente and similar health plans has led the doctors to offer service benefits in nine Blue Shield plans which have no income limitation, and the public seems to prefer the free choice of physicians and hospitals thus offered. The family income limits for service benefits in 47 Blue Shield plans show an average of $4,323 and a median of $4,200 . . .

"The public logically expects their doctors' advice on health insurance to be reliable, but unfortunately most of us have had little opportunity to study insurance principles, policies, or companies. In his own community, a doctor becomes prejudiced against Company A because it rejects so many of his patient's claims, against Company B because the fees for his field of practice appear inadequate to what others are allowed, against Company C because it refuses to pay for accident care at his office when it would have paid for it at the hospital emergency room, against Company D because they rejected payment for a chest roentgenogram in a patient who was hospitalized for duodenal ulcer. . . . When the doctors in a community are convinced that a certain insurance is superior to others, their open support will soon guide their patients to better coverage. So long as the public and the doctors are both confused, much inferior health insurance will be sold, and our patients will suffer. It is the inescapable duty of our profession actively to guide the further evolution of health insurance toward the goal of adequate protection without the wastefulness which now threatens the future of voluntary health insurance."

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Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

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INDEX TO ADVERTISERS

	Page
Ames Company, Inc.	931
Ayerst Laboratories	920
Barr X-Ray Company	788
Benson Optical Company	922
Brown and Williamson Tobacco Corp.	798
Burroughs Wellcome & Co., Inc.	809
Ciba Pharmaceutical Products	916
Coca-Cola Company	800
Cook County Graduate School of Medicine	810
Corn Products Company	804
Davies, Rose & Co., Ltd.	921
Doerflinger Artificial Limb Co.	926
Endocrine Laboratories	789
Foot-so-Port Shoe Company	788
Gyne–Cytology Laboratory	919
Hotel Schroeder	789
House of Bidwell	919
Hurley X-Ray Company	916
Ivanhoe Sanitarium	807
Keeley Institute	915
Kennedy–Mansfield	918
Lakeside Laboratories	807, 919, 925
Lederle Laboratories	810, 854, 855
Lilly, Eli and Company	814
Linde Air Products	930
Mallard, Incorporated	926
Mallatt Pharmacy	918
Mather Pharmacy	918
Medical Protective Company	916
Merck, Sharp and Dohme	792, 793, 796, 797, 799, 801, 917, 929
Milwaukee Sanitarium Foundation, Inc.	932
New York Polyclinic	924
Orthopedic Appliance Company	788
Parke, Davis and Company	786, 787
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	794, 805
Physicians Casualty Association	807
Pogue, Mary, School, Inc.	915
Professional Business Service	911
Rennebohm's	918
Riker Laboratories, Inc.	811
Rogers Memorial Sanitarium	932
Sacred Heart Sanitarium	810
St. Croixdale Sanitarium	789
Schering Corporation	790, 791, opposite 802, 812, 813
Schieffelin and Company	926
Searle, G. D. and Company	905
Shorewood Hospital Sanitarium	919
Smith, Kline & French Laboratories	803, 808
Squibb, E. R., & Sons, Div. of Mathieson Chemical Corp.	802
Time Insurance Company	909
Wallace Laboratories	806
Winthrop Laboratories, Inc.	795
Wisconsin Neurological Foundation	800
Wyeth	923

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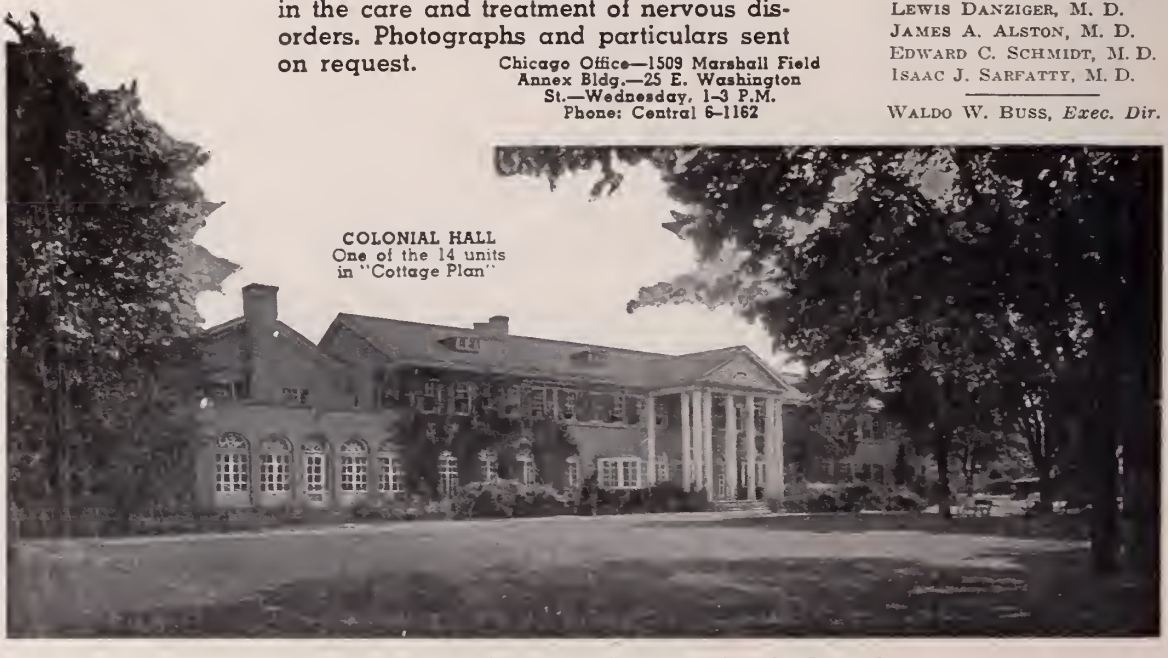

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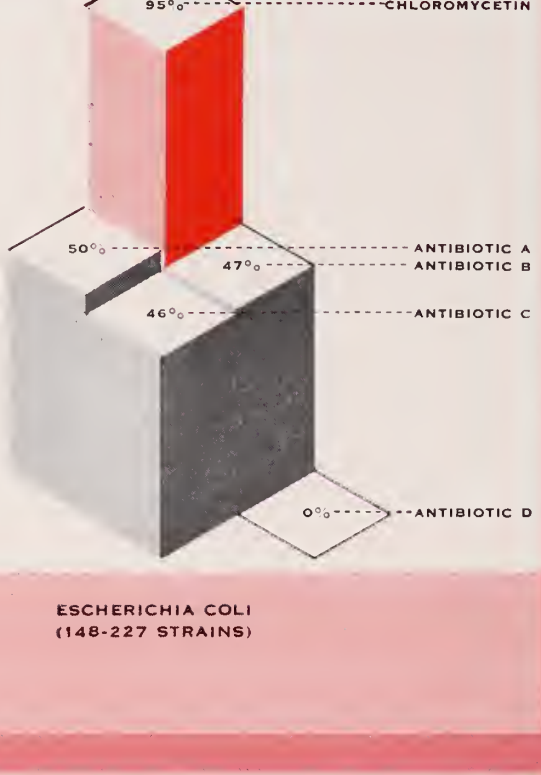
SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND FOUR OTHER MAJOR ANTIBIOTIC AGENTS



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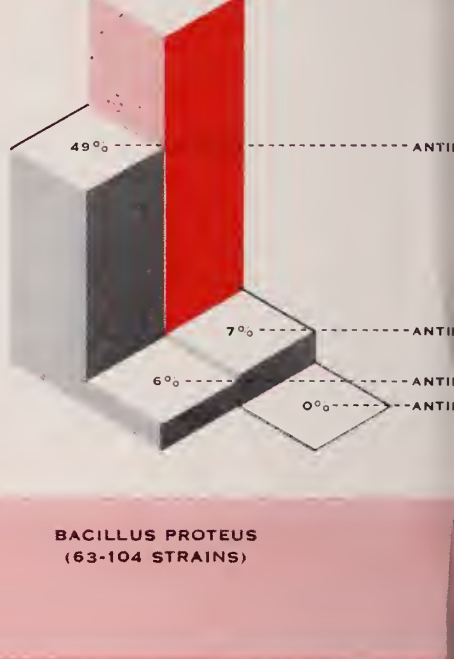

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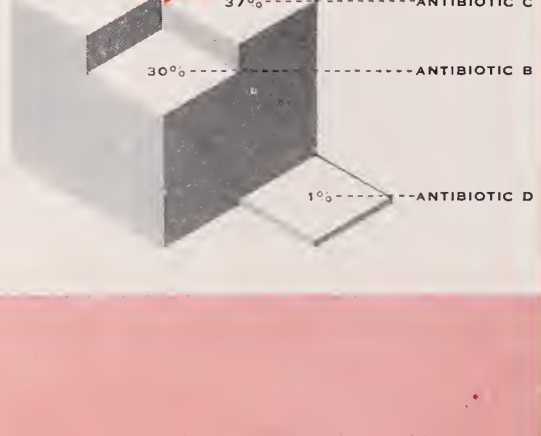

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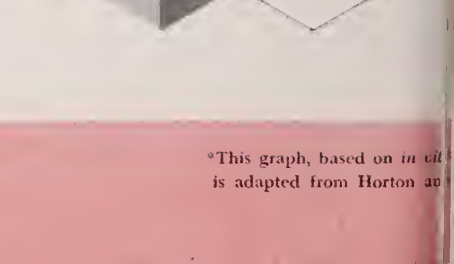

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Trauma and the Urinary Tract, by James W. Sargent, M. D.	965
Typhoid and Paratyphoid Fever; Report of Six Cases with One Death, by E. S. Olson, M. D., and Silas Farmer, B.S.M.T. (ASCP)	968
Treatment of Eczema Vaccinatum by Specific Gamma Globulin; A Case Report, by Max J. Fox, M. D., and Vincent B. Pica, B. S., M. S.	972
Cold Wave Dermatitis, Complications and Treatment, by James J. Barrock, M. D.	977
The Commonly Used Toxic Solvents, by Louis W. Spolyar, M. D.	984
Comments on Treatment	988
Clinicopathologic Conference	989
Highway Safety Is a Health Problem, Too	998

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	Page
Gleanings from the Section on Medical History	1007
Facts About Wisconsin Physicians Service	1009
Society Proceedings	1010
News Items and Personals	1012
Third and Twelfth Districts News	1015
Society Records	1016
Obituaries	1018
The Journal Bookshelf	1022
Physicians' Exchange	1034
Index to Advertisers	1037
List of Officers and Scheduled Meetings of County Medical Societies	1038

EDITORIALS

The President's Page	1000
Surprising Results from Annual Meeting Survey	1001
Let's Focus Attention on Needs of the Aging	1002
Press Reaction to Social Security Expansion	1003

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Erythromycin in the treatment of osteomyelitis*

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

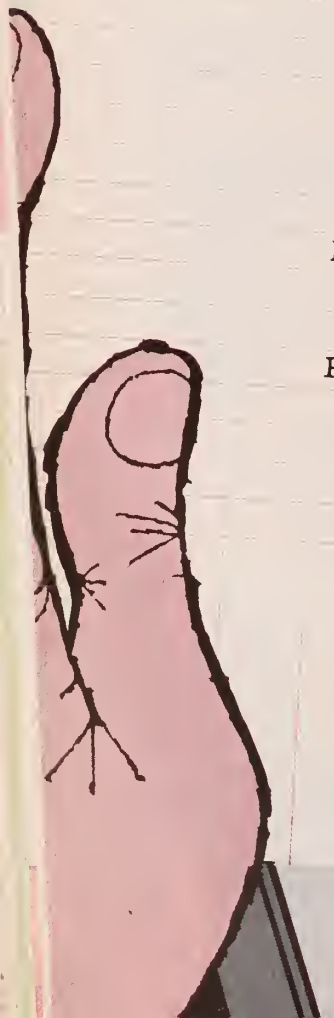
On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.



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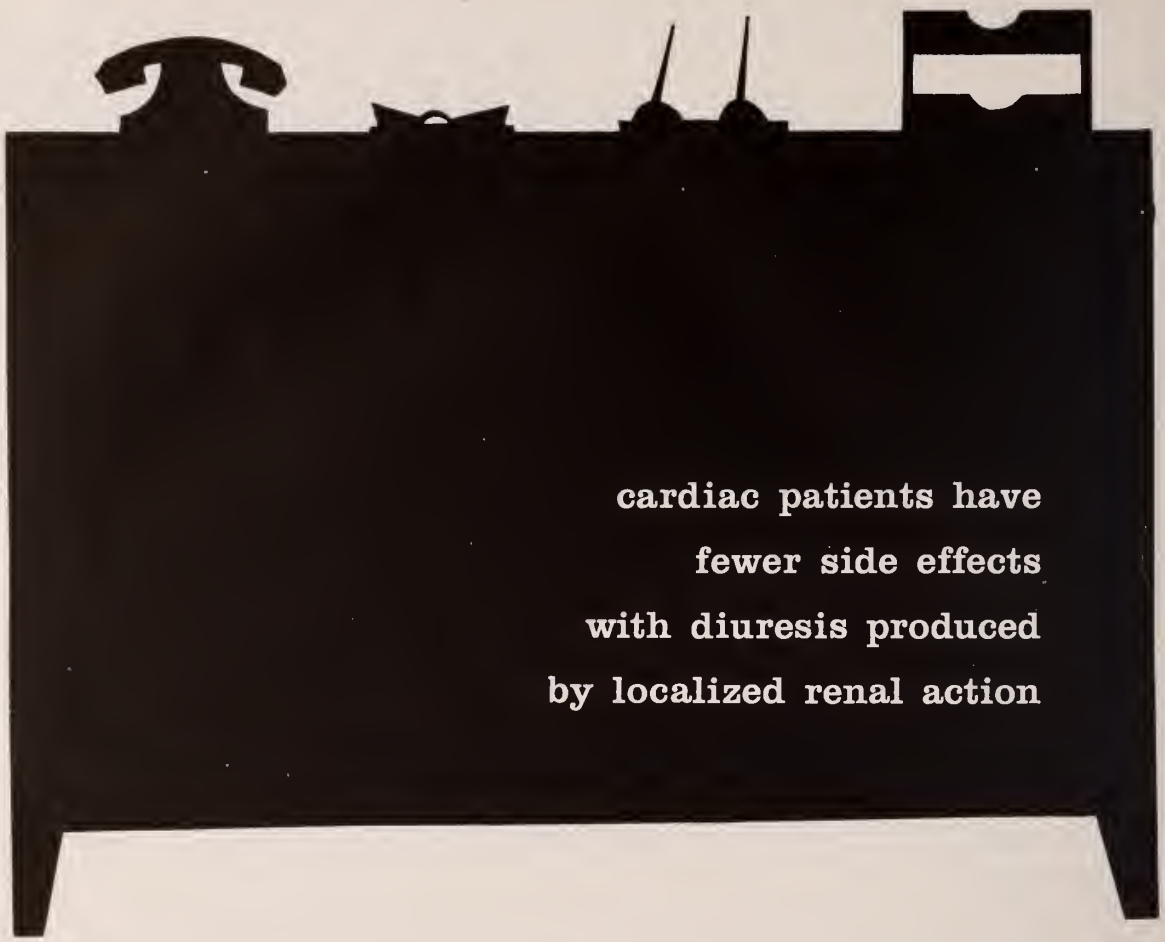

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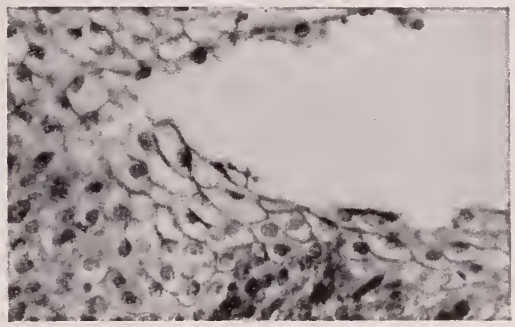

TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

Penetrates thoroughly — This new and unique trichomonacide spreads out and wets the entire vaginal surface. It rapidly dissolves mucinous materials, fats and blood clots.[1] It penetrates the cellular debris that lines the vaginal walls and shields the parasites, reaching trichomonads deep in their hiding places.

Explodes trichomonads — VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[2] Two surface-acting agents and one chelating agent combine to weaken the cell membrane, to remove the waxes and lipids, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

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Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

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1. Odel, H. M.: Nutrition in Cardiovascular Disease, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Dietotherapy, Philadelphia, Lea & Febiger, 1955, p. 709.

2. Berg, C. P.: Utilization of Protein, J. Agr. & Food Chem. *3*:575 (July) 1955.

3. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, Williams & Wilkins, 1955, p. 638.

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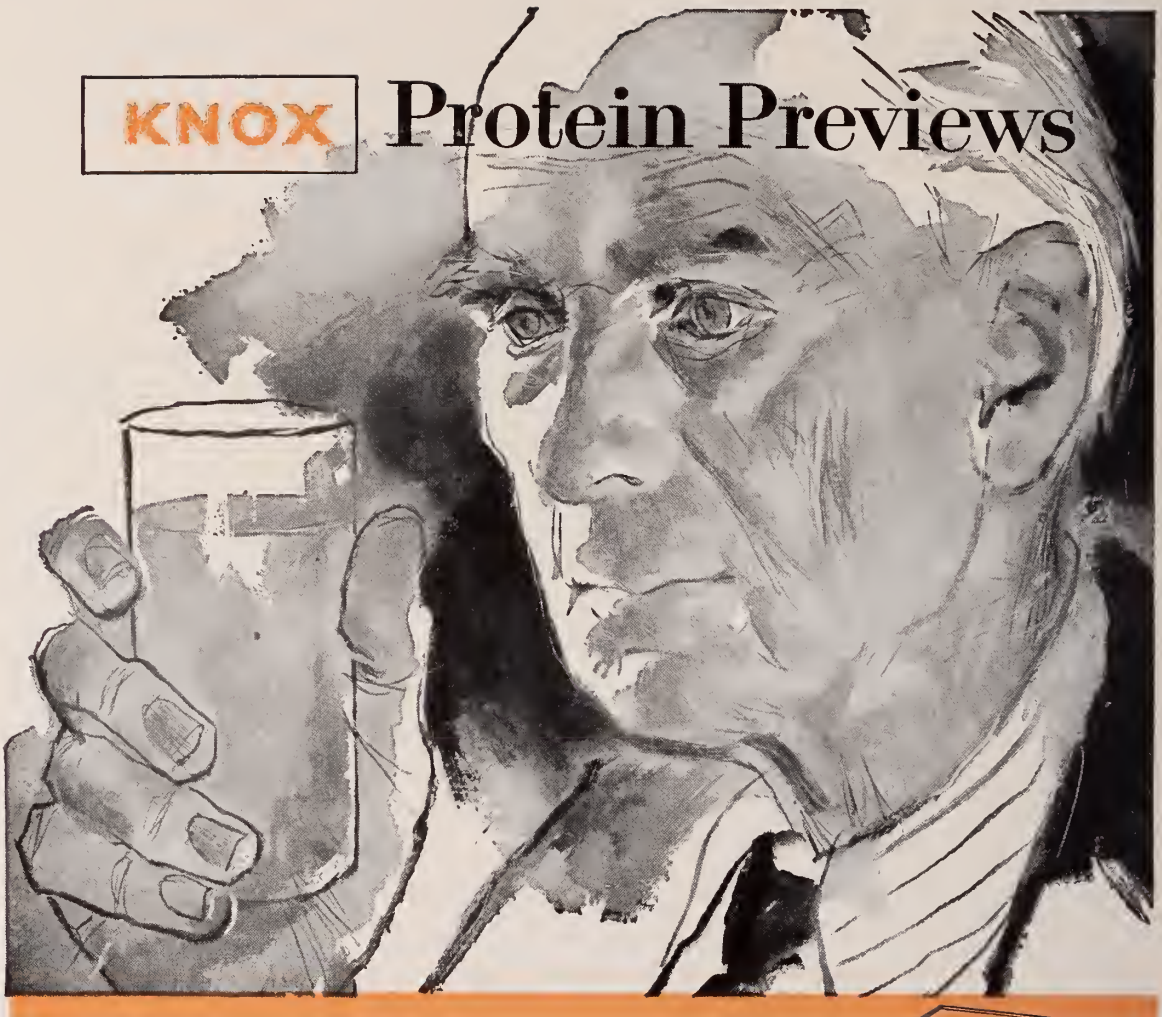

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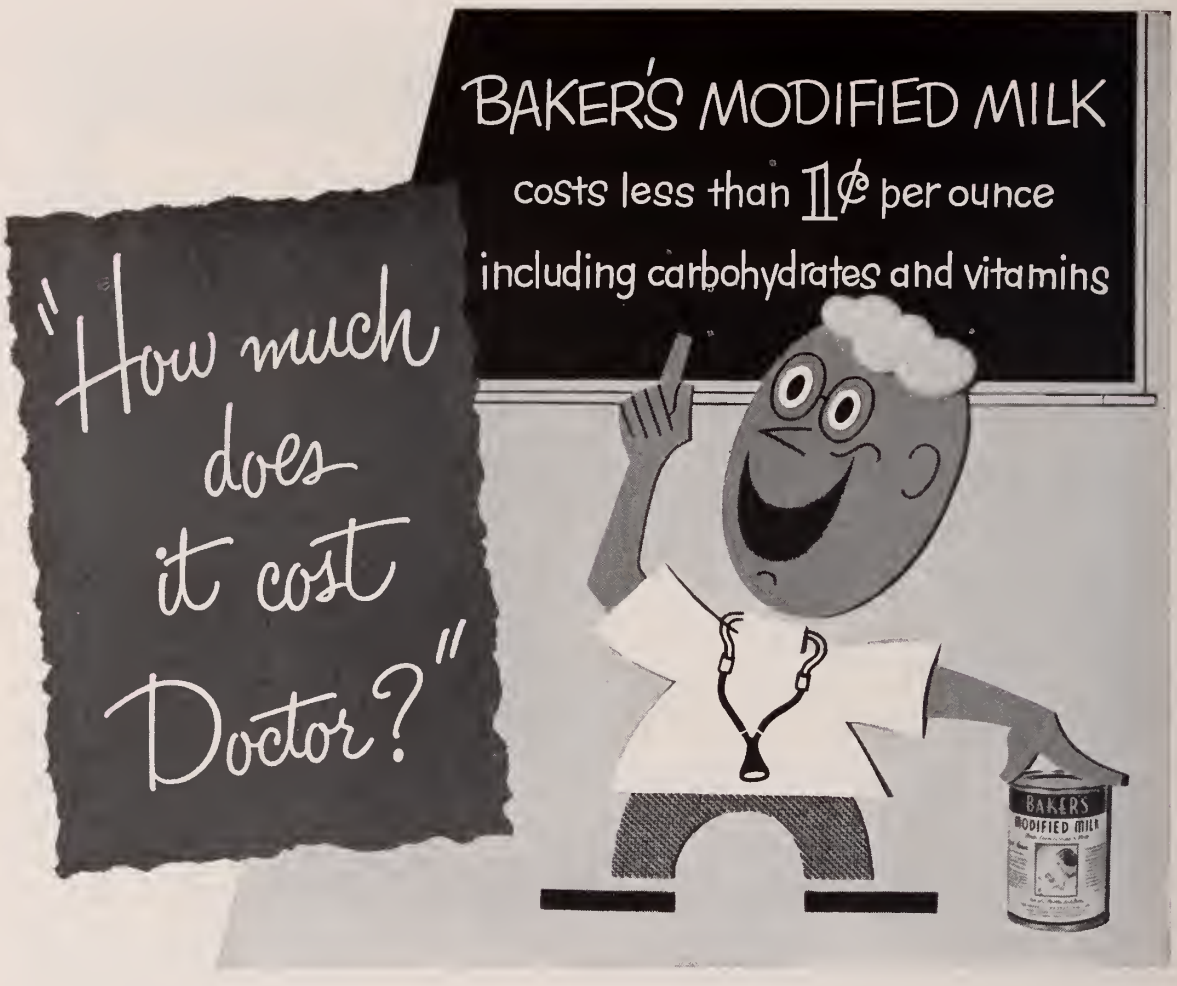

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Pediatric Bibliography

1. Wikler: The Use of Chlorpromazine as an Anti-emetic in Children, Arch. Pediat. *72*:197 (June) 1955.
2. Daeschner et al.: Chlorpromazine in the Control of Vomiting in Children, Am. J. Dis. Child. *89*:525 (May) 1955.
3. Steigman and Vallbona: Chlorpromazine, A Useful Antiemetic in Pediatric Practice, J. Pediat. *46*:296 (March) 1955.
4. Steigman and Vallbona: Experience with Chlorpromazine in Pediatrics, Internat. Rec. Med. & Gen. Pract. Clinics *168*:351 (May) 1955.
5. Moyer et al.: Clinical Studies of an Anti-emetic Agent, Chlorpromazine, Am. J. M. Sc. *228*:174 (Aug.) 1954.

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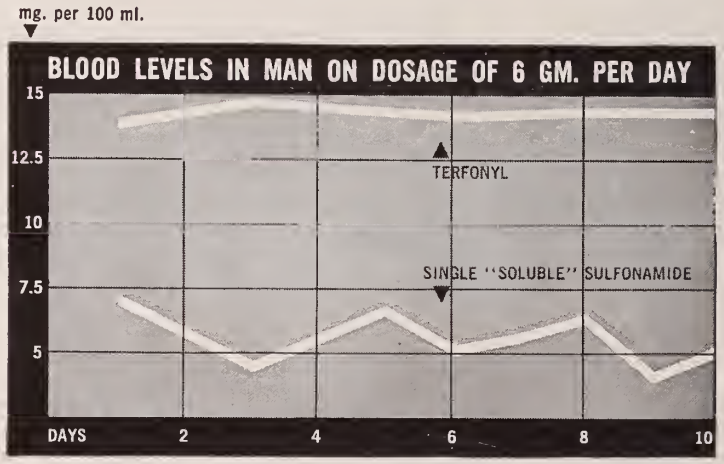

– After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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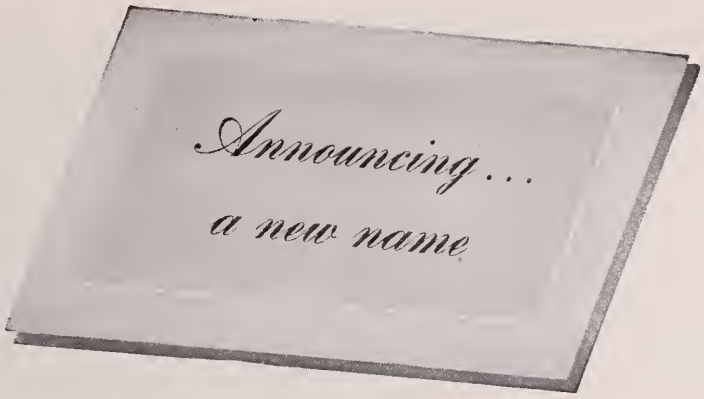

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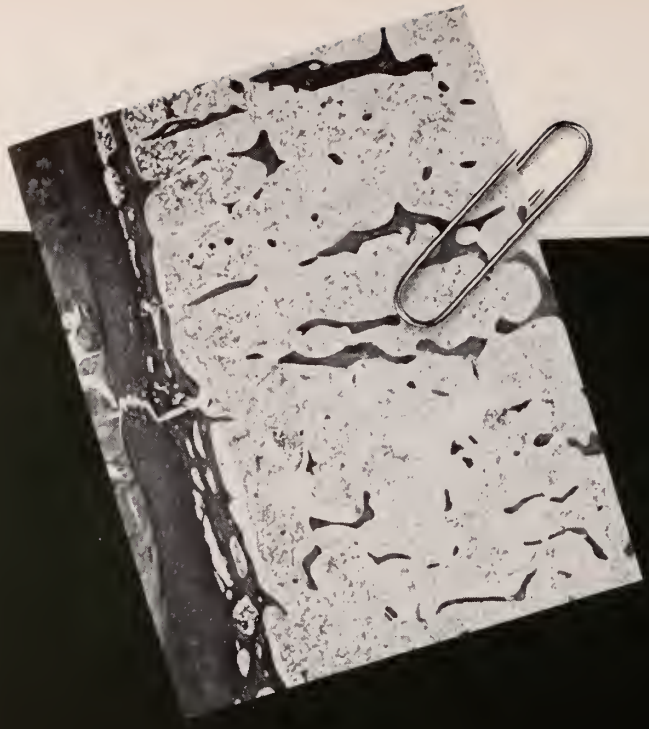

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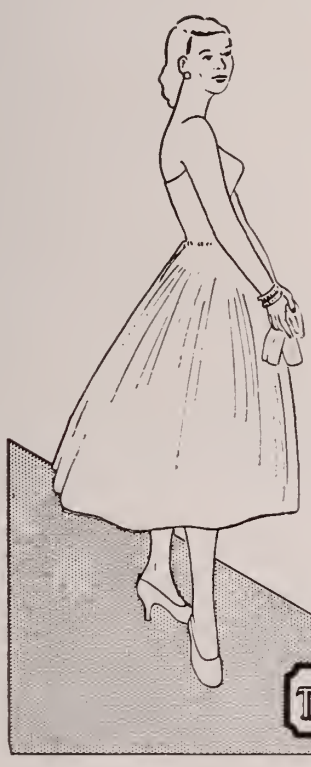

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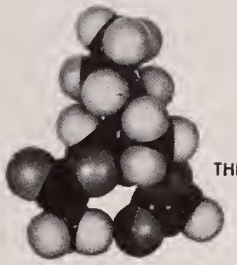

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THE WISCONSIN MEDICAL JOURNAL

Volume 55 SEPTEMBER 1956 Number 9

Trauma and the Urinary Tract

By JAMES W. SARGENT, M. D.*
Milwaukee

INJURIES of the urinary tract are of importance because of two dire consequences. The first and most obvious is fatal hemorrhage from an injured kidney. Fortunately, fatal hemorrhage from a ruptured kidney is not a common consequence of renal trauma; but it always must be anticipated even in the presence of relatively minor abdominal injuries. And, in fact, it often is very difficult to determine if a broken kidney is a likely source of potentially fatal hemorrhage.

A second and equally serious consequence of trauma to the urinary tract is perhaps not as well understood, or at least is not usually given serious enough consideration. This is urinary extravasation.

Urine in raw tissues is an extremely toxic agent. Any time the continuity of the urinary tract is disrupted and urine is allowed to penetrate into raw tissues, the results are predictable, very dramatic, and often disastrous. Take, for example, the patient with an unsuspected rupture of the urethra. For a while after injury, reflex mechanisms prevent the patient from voiding. Sooner or later, however, nature commands. The patient starts to void. No urine comes out of the penis, and the patient experiences the horrible sensation of voiding into his own perineum. The urine causes a violent reaction in the raw tissues, producing necrosis and later a woody phlegmon with secondary suppuration and sepsis that often leads to the patient's death. All this from a simple rupture of the urethra that was not suspected in time.

In view of these two serious consequences of urinary tract trauma, and in view of the increasing frequency and severity of industrial as well as highway accidents, more serious consideration must be given to the various aspects of urinary tract injuries. Often in highway accidents the injured kidney is only a part of more extensive injuries such as the opened chest, the broken liver, the ruptured bowel, etc. In such cases the physician usually temporizes in treatment of the injured kidney, and I think rightly so. Certainly, if the patient is to live at all, the more demanding injuries must be treated first. Of more concern, however, is the injured kidney that is not associated with other severe injuries. Strangely enough, the position of the kidneys anatomically is not as protective as it would seem; and relatively minor trauma, even without any external evidences of violence, may cause extensive damage to the kidney.

In all cases of possible kidney injury the most important thing is to be aware that serious damage to the kidney may result from relatively minor trauma. Once kidney damage is suspected, the patient should be catheterized immediately. If the urine is grossly bloody, it then becomes imperative to obtain an excretory urogram. This not only provides essential information about the opposite kidney, but may give sufficiently detailed information concerning the injured kidney. If finite detail is not obtained, a retrograde urogram is then imperative.

Once the extent of the kidney damage has been assessed accurately, the course of treatment is still somewhat controversial. Some favor immediate nephrectomy for all injured kidneys. However, a more conservative approach is generally gaining favor for several reasons. The first involves the astounding ability of the royal tissue of the kidney to control its own hemorrhage and to undergo anatomic and functional recovery. In addition the majority of all kidney injuries are actually relatively minor, and fatal hemorrhage is not the rule. Of course, the patient with a totally shattered kidney who is not in shock must have an immediate nephrectomy before shock ensues. If the patient is in shock, the shock must be controlled before

* Assistant Clinical Professor of Urology, Marquette University School of Medicine.

nephrectomy is attempted. If it cannot be controlled, then operating in the presence of shock will only ensure the patient's death. Shock must be controlled first and then, and only then, if nephrectomy is indicated may it be done with relative safety.

The majority of patients, even of those with rather extensive lacerations, can usually be treated by general supportive measures, transfusions as indicated, and strict bed rest. It is important to keep these patients flat in bed for a period of at least two weeks following the last day of gross hematuria. The danger of secondary hemorrhage 10 to 14 days after injury must always be borne in mind.

Injuries to the Ureter

Injuries to the ureter can be easily and simply prevented. The placement of ureteral catheters immediately prior to pelvic surgery is such a simple procedure and of such inestimable value in protecting against ureteral injuries that it should be a routine part of all pelvic surgery.

It is pure conjecture to consider the number of ureters that have been tied off without the patient's or the surgeon's being aware of it. Increasing reports are coming in of patients having urologic surveys for unrelated conditions in whom a nonfunctioning kidney has been found. These patients are found to have impassable obstructions in the lower ureter, and all have histories of pelvic surgery years previously. The obvious conclusion is that many ureters are tied off without anyone's knowing of it.

The more typical picture of ureteral injury is that of an uneventful convalescence from pelvic surgery. Perhaps the patient has been dismissed from the hospital. Ten to fourteen days after surgery profuse vaginal drainage of urine suddenly develops. If, in spite of the vaginal drainage of urine, the patient continues to void normally, it is indicative of a ureterovaginal fistula. Even knowing this, the patient often cannot tell which side has been involved as, in the absence of infection, the symptoms are so minimal.

If the diagnosis is established, and if the opposite kidney is normal, the usual treatment is nephrectomy. Deligation is to be condemned unless the injury is detected within a matter of hours. Reimplanting the ureter into bladder, bowel, or skin carries an increased mortality as well as marked increased morbidity from various complications. Most of these patients are past middle age, and for the most part nephrectomy is the simplest and safest procedure.

Injuries to the Bladder and Urethra

Injuries to the bladder and urethra are common complications of fractures of the pelvis. The urethra may also be severed distal to the sphincters by a straddle injury; the patient falls astride a fixed object such as a fence or a ladder rung, and the forceful compression of the perineum against the symphysis severs the urethra completely. The bladder may also suffer a "blow-out" rupture from a fall or a blunt blow above the pubis when the bladder is distended. The increasing use of safety belts may become a factor in this "blow-out" type of bladder rupture by exerting sudden pressure over a distended bladder.

Most commonly a fragment of the pubis or ischium sweeps into the true pelvis, lacerating the bladder or completely severing the urethra. Since these fragments may snap back into relatively good alignment, the radiographic evidence of displacement of the bones cannot be taken to exclude injuries to the deeper pelvic organs.

With the ruptured bladder or urethra it is truly a matter of "the quick or the dead." The urethra must be repaired before the patient voids into his own perineum. The bladder must be repaired and the pelvis drained liberally to prevent the disastrous sequelae of urinary extravasation.

Most important is the immediate diagnosis of these injuries, and this can be accomplished quite simply. All patients suspected of having these injuries must be catheterized immediately. If the catheter passes freely to the bladder, one can be reasonably certain that the urethra is intact. If the catheter passes only part way and then becomes "lost" in the soft tissues, and especially if on withdrawal of the catheter some fresh blood and clots follow, the diagnosis of ruptured urethra is made and immediate cystotomy is indicated. If the catheter passes freely but releases only a few drops of bloody urine, a ruptured bladder must be suspected. A measured amount of sterile solution may then be injected. If the same amount of fluid can then be aspirated, the bladder is probably intact. The best procedure is to inject

some radiopaque material into the bladder and take antero-posterior and oblique exposures over it. Any evidence of extravasation may then be seen; and, if present, immediate cystotomy and drainage are indicated.

Summary

Urinary tract injuries are characteristically so silent that many valuable hours may be lost before they are even suspected. The patient with a fractured pelvis may extravasate urine for hours before a ruptured bladder is suspected. Or, the man unconscious from a head injury may bleed to death from an unsuspected ruptured kidney.

How can we evaluate the status of the urinary tract promptly and simply? There is one simple procedure that can be done so easily and is so important that it should be made a standard procedure in the initial emergency examination of all accident victims. This is the simple passage of a urethral catheter. The victim must be catheterized immediately, preferably in the emergency admitting room.

Why is this simple passing of a catheter so important? It tells us all this about the urinary tract:

(1) If the catheter passes freely into the bladder, we can be reasonably certain that the urethra is intact.

(2) If the catheter passes freely into the bladder and little or no urine is obtained, we must suspect a ruptured bladder.

(3) If the catheter passes freely and releases a good quantity of grossly bloody urine, the upper urinary tract has been injured.

(4) If the catheter passes freely and a good quantity of clear urine is obtained, we can be reasonably certain that the urinary tract has been spared.

324 East Wisconsin Avenue.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS MEETING

The American College of Obstetricians and Gynecologists will hold its meeting at the Palmer House, Chicago, on November 7–9.

Two hundred round tables and one hundred breakfast conferences have been scheduled; leaders of these discussions will be Fellows of the college and guest speakers with special knowledge on the particular subjects. Three panel discussions—dealing with anesthesia in obstetrics, problems concerned with adoption, and pathology of the breast—will be offered. Several formal papers will also be presented. An innovation will be the "consultation hours," to be held four times during the meeting. At each, a panel of three specialists will undertake to answer questions presented to them before the session or while it is in progress.

The annual banquet will be held on Thursday evening, November 8.

There is no registration fee for Fellows or Junior Fellows of the college. Candidates for fellowship or junior fellowship whose names have been published in the *ACOG Newsletter* will have a registration fee of $10. Residents in obstetrics and gynecology may register without charge upon identification. The fee for all other persons will be $20.

Three days of entertainment have been arranged for the wives of physicians attending the meeting.

Typhoid and Paratyphoid Fever

Report of Six Cases With One Death

By E. S. OLSON, M. D., and SILAS FARMER, B. S. M. T. (ASCP)
Racine

INTRODUCTION

IT IS the purpose of this paper to present 6 cases of *Salmonella* infection that occurred in a three-month period in Racine County. Five of the cases presented protean clinical findings. We also plan to discuss some diagnostic and epidemiological features of this condition.

Typhoid and paratyphoid fever are called Salmonella because they are similar biochemically, antigenically, and pathogenically. There are epidemiological and clinical differences.

INCREASED INCIDENCE

There is a renewed interest in *Salmonella* infections. Sporadic cases of typhoid and paratyphoid infections have occurred in Nebraska, Iowa, Illinois, and Michigan, as well as in Wisconsin, during the first part of 1956.

There appears to be a common source for most of the infections. Almost all of the cases are phage type E_1.[1] The source has not been found, but Christmas candy was considered. We believe frozen fruit juices and other similar edibles that have a wide distribution must be considered as a possible source of infection.

Milwaukee had 16 cases of typhoid fever from 1946 to 1955. Four cases of typhoid were reported in the first five months of 1956.[1] This is a notable increase in incidence of this condition.

Racine County had one case of typhoid fever in the 10-year period ending in 1955. This was reported in 1947. There was one case of paratyphoid B in the same interval; it was reported in 1953.[2] We found 6 cases of *Salmonella* infections from February through April of 1956, which is a notable increase in this county, too.

The Wisconsin State Board of Health reported an incidence of from 13 to 30 cases of *Salmonella* infections for the past 10 years, with an average of 22.3 cases a year. There were 21 scattered cases during the first four months of 1956, another instance of a marked increase over previous years.[3]

During 1954, nine states and the District of Columbia reported a total of 16 outbreaks of typhoid fever, with a total of 92 cases. There were 26 outbreaks of "Salmonellosis" reported from 12 states and one territory, with a total of 1,164 cases.[4]

SOURCE OF INFECTION

Typhoid is commonly transmitted by means of water and also by milk.[5] Both typhoid and paratyphoid fever are transmitted by means of contaminated food.

There were 100,000 cases of typhoid in France from 1919 to 1933, with 25,000 deaths. The source of infections was attributed to shellfish.[5] Flour is a good way to keep the paratyphoid organism viable.[5] If it is damp, the organisms will multiply.[6] The infection can be introduced in bakeries by this means. Creamcake is the most common vehicle for paratyphoid infection in Britain.[5]

Immunization does not offer complete protection. Immunized personnel have developed explosive outbreaks in military camps.[7]

BACTERIAL INVASION

The organisms pass from the gastrointestinal tract into the mesenteric glands and then enter the blood stream. This takes from 7 to 10 days. This is when the blood cultures are positive. The organisms multiply in the bile and involve the Peyer's patches, which takes two to three weeks. This results in a positive stool specimen. During this step the antibodies develop. The role of antibodies in clinical recovery is uncertain.[8]

DISEASE CHARACTERISTICS

Some of the cases are mild. In one family of 15, there were three classical cases. Four had only a mild febrile illness for a few days, and two were symptomless but had a positive Widal. The symptoms may be those of influenza, and the white blood cell count may be up to 20,000.[5] Death seldom occurs in *Salmonella* infections other than typhoid, except in the aged. The one death in our series was due to paratyphoid in an aged, neglected patient.

LABORATORY DIAGNOSIS OF S. *TYPHOSA*

The serological diagnosis of *Salmonella typhosa* infections involves the H and O agglutinins. These are associated with the Widal reaction. An anamnestic reaction can

occur if the patient has been vaccinated recently. Under such circumstances there is usually an early rise in the titer with a relatively rapid fall.[8] In the actual disease the titer is usually higher and persists longer. The isolation of the organism establishes the diagnosis. Known serums are used for classification.

Vi antigens were first discovered in 1934. They are located on the surface of the cells. The antigen is particularly present on organisms isolated from the blood. It is located exterior to the periphery of the O antigen. It may protect the organism from the agglutinating action of anti-O serum.[9] The presence of Vi antibodies in the blood is significant. Typhoid vaccine usually does not cause the formation of Vi antigens.[8] They are not always present in typhoid cases.

Testing for Vi agglutinin is of great value in preliminary screening for chronic carriers. [5, 10] Only those that show the presence of this agglutinin need to have their urine and feces tested. If the Vi agglutinin is positive when the patient is discharged from the hospital, testing should be repeated in three months. If it is still positive, further examination of the stools and urine should be carried out.[5] Approximately 3% of the typhoid patients become chronic carriers.[5,8] In Norway, Vogelsang reported 1.9% chronic carriers among patients with paratyphoid B infections.[11]

PHAGE TYPING

Strains of *Salmonella* are identified by using specific bacteriophages. This is called phage typing. Strains that are related epidemiologically are invariably found to react in an identical manner to the different adapted phage preparations.[8] These strains cannot be identified by any other known technique. Twenty-four types and subtypes were suggested in 1947,[12] and nine other types have been added.[10] The most common Vi-phage type throughout the world is E_1. Type A held first place in Britain for seven out of eight years. Certain types do not occur in some parts of the world and are common in others. There is a relative frequency of untypable Vi-strains, which are termed "Degraded Vi-Strains."[10]

In 1943 it was found that it was possible to apply the bacteriophage technique to the typing of *Salmonella paratyphi B*.[5]

The phage technique often permits one to trace the spread of an infection, localize its source, connect the sporadic cases with one another, pinpoint single or multiple sources of infection in an outbreak, and indicate particular carriers as the source or absolve others.[5]

The organisms must be forwarded to the State Board of Health which, in turn, forwards them to a certified Salmonella center. Such centers have world-wide recognition. In this way types that are common in one foreign country but are rare or practically nonexistent in another country might be traced to their source.

TREATMENT

Chloramphenicol is effective in treatment. It is said that the drug should not be given for longer than a six-day period.[5] Others recommend 1 gm. daily for three to four weeks.[8] Results are noted in 48 hours regardless of the stage of the disease. Intestinal ulcerations may persist for several days, even after the temperature is normal. Hemorrhage and perforation may occur during the afebrile period.[5] A relapse may occur up to 30 days after the fever has subsided. The treatment does not prevent the patient from becoming a chronic carrier. This is thought to be due to a lack of immunity. It has been suggested that 0.1 ml. of the vaccine be given intramuscularly three times weekly for two weeks. This may be started immediately or after the temperature has subsided.[5]

The organisms can be found in the feces or urine for one to two months. If they persist for three months, spontaneous recovery may not occur. The carrier state is uncommon in young people. The incidence is more common in elderly persons.[5] Those with a Vi agglutination of 1 to 5 in their blood stream were thought to be carriers. However, not every carrier has the Vi agglutinins and not every patient with persistent Vi agglutinins can be demonstrated to be a carrier. Nevertheless, the Vi agglutinin factor is of great value in preliminary screening. Only those with Vi agglutination present need have their urine and feces tested.[5]

In isolating the organism, Moore used pads of gauze fastened in sewers through the manhole and permitted to remain there for 48 hours. Organisms have been regularly isolated by this technique.[13] In this way the organisms could be localized to certain areas in a city that might be the source of an epidemic.

When the organisms are found in duodenal

aspirations, a cholecystectomy should be considered. Up to 90% of the cases are cured by this procedure.[8]

Foci of disease may persist in the liver, spleen, lymph glands, bone marrow, kidneys, and possibly elsewhere. There are granulomas consisting of lymphocytes, mononuclear cells, occasional giant cells, and some supporting stroma. They often have necrotic centers. It is believed that organisms enter the blood stream periodically from such foci. There is no known treatment that will clear up the foci.[5]

TYPHOID CASES

Case 1

This patient was 21 years of age. She complained of chills, fever, and headache. The temperature went up to 104 F. An extensive ulceration developed on the labia minora. Cultures taken after she was on antibiotic therapy for several days showed hemolytic staphylococcus. Blood cultures taken six days after the onset of the illness showed *Salmonella typhosa*. The febrile agglutinations were negative at this time. The white blood cell count was 4,100. The patient responded to Chloromycetin.

Case 2

This patient was 53 years of age. He had chills, fever, and headache. The temperature went up to 101.4 F. He was dull mentally. He said he had had epigastric cramps while eating for six weeks. There was a history of tuberculosis in 1934. A tuberculous meningitis was considered. The lungs were negative. The blood and stool cultures were positive for *Salmonella typhosa*. These were taken five and six days respectively after the patient entered the hospital. The febrile agglutinations were 1:160 for the O and H antigens three days after admission. The O went to 1:800 and the H to 1:400 in two weeks. The Brucella went up to 1:800, which was an anamnestic reaction. The spleen was palpable. The patient was treated with Chloromycetin.

Case 3

This patient was 14 years of age. She complained of fever, pain in the chest, and headache for one week. The temperature went up to 104.6 F. She said she could not see at times. A cough was present for several days. An x-ray of the chest was normal. A blood culture taken four days after the patient was admitted to the hospital was positive for *Salmonella typhosa*. The C-reactive protein was a weak positive. The febrile agglutinins were negative. The white blood cell count was between 4,800 and 6,300. The patient responded to Chloromycetin.

PARATYPHOID CASES

Case 1

This patient was 2 years of age. There was diarrhea and fever for two days. Blood was noted in the stools. The temperature went up to 102.6 F. The white blood cell count varied between 4,700 and 8,300. Paratyphoid B was isolated from the stools. There was good response to Chloromycetin.

Case 2

This patient was 2½ months of age. There was diarrhea for two days along with fever. The patient was blue and cold when admitted to the hospital. There was hyperreflexia, with some spasticity of all the extremities. An upper motor neurone lesion was considered and also an infantile tetany. The blood calcium and electrophoretic studies were normal. The spinal fluid was negative. A stool culture showed paratyphoid B. The white blood cell count varied between 8,800 and 10,300. The temperature went up to 103 F. The patient responded to Chloromycetin.

Case 3

This patient was 75 years of age. She was in critical condition upon admission, and no history could be obtained from her or the relatives. It was known that she had had abdominal pain and diarrhea for two months. There were some moist rales in the lungs, but there were no other definite findings on physical examination. She died three days after she was admitted. A possible malignancy of the gastrointestinal tract was considered. A stool culture showed the presence of paratyphoid C. This was reported after the patient expired. The post-mortem examination showed ulcerations of the ileum and large bowel.

SUMMARY

Three cases of typhoid fever and three cases of paratyphoid fever have been presented. One elderly patient with paratyphoid infection had been neglected before she was seen by a physician and died before a diagnosis was established. Five of these cases presented confusing manifestations. In one

of the typhoid patients, there was an ulceration on the labia minora. Anotner patient stated she could not see at times. The third patient was dull mentally and had a history of tuberculosis so a tuberculous meningitis was considered. He also had a high titer to Brucella, which was an anamnestic reaction. One paratyphoid patient was a child; and because of spasticity with hyperreflexia, an upper motor neurone lesion was considered and also infantile tetany. Another patient with paratyphoid that died shortly after she entered the hospital was considered to have a malignancy of the gastrointestinal tract.

The symptoms in these cases cleared up under proper management. There was no known source for the infections. Hemorrhage from the gastrointestinal tract and also perforation may occur after symptoms have subsided under drug therapy. The patient cannot be considered cured just because symptoms have subsided. Small doses of vaccine have been recommended along with drug therapy.

Some cases are mild and can easily go undiagnosed or be considered to be influenza.[8]

St. Luke's Hospital.

REFERENCES

1. Krumbiegel, E. R., Health Department, City of Milwaukee: Personal communication to the authors, May, 1956.
2. Edwards, A. C., Department of Health, Racine, Wisconsin: Personal communication to the authors, May, 1956.
3. Feig, M., Wisconsin State Board of Health: Personal communication to the authors, May, 1956.
4. Dauer, C. C., and Sylvester, G.: 1954 summary of disease outbreaks, Pub. Health Rep. 70:536–544 (June) 1955.
5. Banks, S.: Enteric fever and food poisoning, Practitioner 174:677-682 (June) 1955.
6. Thomson, S., cited by Banks, S.: Enteric fever and food poisoning, Practitioner 174:677–682 (June) 1955.
7. Marmion, D. E., cited by Banks, S.: Enteric fever and food poisoning, Practitioner 174:677–682 (June) 1955.
8. Cecil, R. L., and Loeb, R. F., editors: Textbook of Medicine, ed. 9, Philadelphia and London, W. B. Saunders Company, 1955, p. 222.
9. Miller, S. E.: Textbook of Clinical Pathology, ed. 5, Baltimore, Williams & Wilkins, 1955, p. 597.
10. Felix, A.: World survey of typhoid and paratyphoid—B phage types, Bull. World Health Organ. 13:109–170, 1955.
11. Vogelsang, Th., cited by Banks, S.: Enteric fever and food poisoning, Practitioner 174:677–682 (June) 1955.
12. Craigie, J., and Felix, A.: Typing of typhoid bacilli with Vi bacteriophage; suggestions for its standardisation, Lancet 1:823–827 (June 14) 1947.
13. Moore, B., cited by Banks, S.: Enteric fever and food poisoning, Practitioner 174:677–682 (June) 1955.

GASTROENTEROLOGICAL CONVENTION AND COURSE IN POSTGRADUATE GASTROENTEROLOGY

The annual convention of the American College of Gastroenterology will be held at the Roosevelt in New York City on October 15, 16, and 17, 1956.

The program will feature six panel discussions on diseases of the gastrointestinal tract, one to be presented by each of the six medical schools in New York City. In addition, there will be individual papers and a special motion picture program. The sessions will be open to all physicians without charge.

Following the convention the annual course in Postgraduate Gastroenterology will be given at The Roosevelt and the new Metropolitan Hospital Center on October 18, 19, and 20.

The course will be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, professor of surgery, University of Minnesota Medical School, and Dr. I. Snapper, director of medical education, Beth-El Hospital, Brooklyn, N. Y.

The subject matter to be covered in the course, from a medical as well as surgical viewpoint, will cover, essentially, the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum, with special studies of radiology and gastroscopy.

The course will be open only to those who have registered in advance.

For copies of the program and further information concerning the postgraduate course write to the American College of Gastroenterology, Department P. G., 33 West 60th Street, New York 23, N. Y.

Treatment of Eczema Vaccinatum By Specific Gamma Globulin

A Case Report

By MAX J. FOX, M. D.,* and VINCENT B. PICA, B. S., M. S.**
Milwaukee

ECZEMA vaccinatum following smallpox vaccination is a serious complication. It is commonly seen in patients with eczema of a congenital ectodermal deficiency. In the past the mortality rate has been as high as 20 to 40%.

In recent years the medical profession has learned the value of gamma globulin in the treatment of viral diseases, and at the present time much work is being done on the idiopathic gamma globulin deficiency syndrome. Recently new therapeutic agents, specific immune gamma globulins, have become available. The following is a report of a case of eczema vaccinatum treated with vaccinia globulin.

Case Report

A 57-year-old, white, married male was admitted to the hospital on Feb. 5, 1955. He had developed a severe vaccinia following contact with his 18-year-old daughter, who had had a chronic eczema all her life and who had received a smallpox vaccination on Jan. 11, 1955, as a part of the routine physical examination given in the course of her application for employment. Four days later she complained of headache, followed, in 48 hours, by a few lesions on her face. On January 20, a severe pruritic, macular, papular, vesicular eruption developed on her face and body; this was accompanied by severe pain in the face, fever, conjunctivitis, photophobia, and nausea. Vomiting or anorexia was not experienced. This syndrome reached its peak in two days and then receded until, 25 days later, the only residual was a red, blotchy, edematous rash on the face.

Her father had been in constant association with her throughout the course of her illness. He indicated he may have been infected through one or more circumstantial ways, such as: (1) helping her to the bathroom, bedroom, living room, or dining room; (2) handling of her eating utensils; (3) direct contact with her towels and linen.

On the day prior to his admission, the father broke out with a severe macular, papular, vesicular eruption over his face, scalp, and body. There was edema and pain in the face, marked headache, tinnitus, marked pruritus, fever, conjunctival injection, photophobia, dryness of the mouth, nausea, malaise, and general arthritic joint pain. These symptoms were present upon admission.

A systematic review of the past medical history revealed an eczematoid skin condition. The patient said he had two brothers who were afflicted with eczema and that, as soldiers during World War I, all three had developed a mild skin reaction following their "shots."

Physical examination revealed a well-developed, well-nourished, white male in acute distress but alert, cooperative, and well oriented. His speech was normal. The blood pressure was 120/80, pulse 108, respirations 20, oral temperature 102.5 F. The neck was freely movable. Both anterior cervical and posterior auricular nodes were slightly enlarged, movable, and nontender. The skin was involved by numerous vesiculopustular lesions on the face, arms, and chest. Some of these lesions were excoriated. There was a marked bilateral cellulitis. The conjunctivae were injected, and a watery secretion was present in both intercanthal folds. The pupils reacted to light and accommodation, and the fields of vision were grossly intact.

The blood count was normal. The differential was as follows: segmented polymorphonuclear leukocytes 55%, stab forms 21%, lymphocytes 15%, monocytes 2%, and eosinophiles 7%. The urinalysis, erythrocyte sedimentation rate, and chest x-ray were normal.

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**Junior Student, Marquette University School of Medicine.

Fig. 1—Photograph of patient taken during the height of the disease.

On February 6 the patient was given 30 cc. of vaccinia globulin intramuscularly. This material was obtained from the University of California. Shortly thereafter his temperature returned to normal. Improvement was rather rapid, and he remained stable until discharge eight days later except for one febrile episode on February 7. A peak temperature of 103.2 F. was reached; this was down to 99 F. four hours later. Blood specimens were drawn in the acute and convalescent phases and sent to the University of California for titer evaluation. The laboratory findings were as follows:

	1st serum (2/6/55)	2nd serum (2/14/55)
Hemagglutination-inhibition titer	1:55	1:640
Complement-fixation titer	Anticomplementary	1:16
Virus-neutralization titer	1:4	1:128

Interpretation: Good antibody response.

The above photograph was taken soon after the patient's entrance to the hospital, during the height of the disease. Figure 2 was taken on February 11, five days following injection of specific gamma globulin.

The administration of this specific vaccinia gamma globulin was followed by rapid

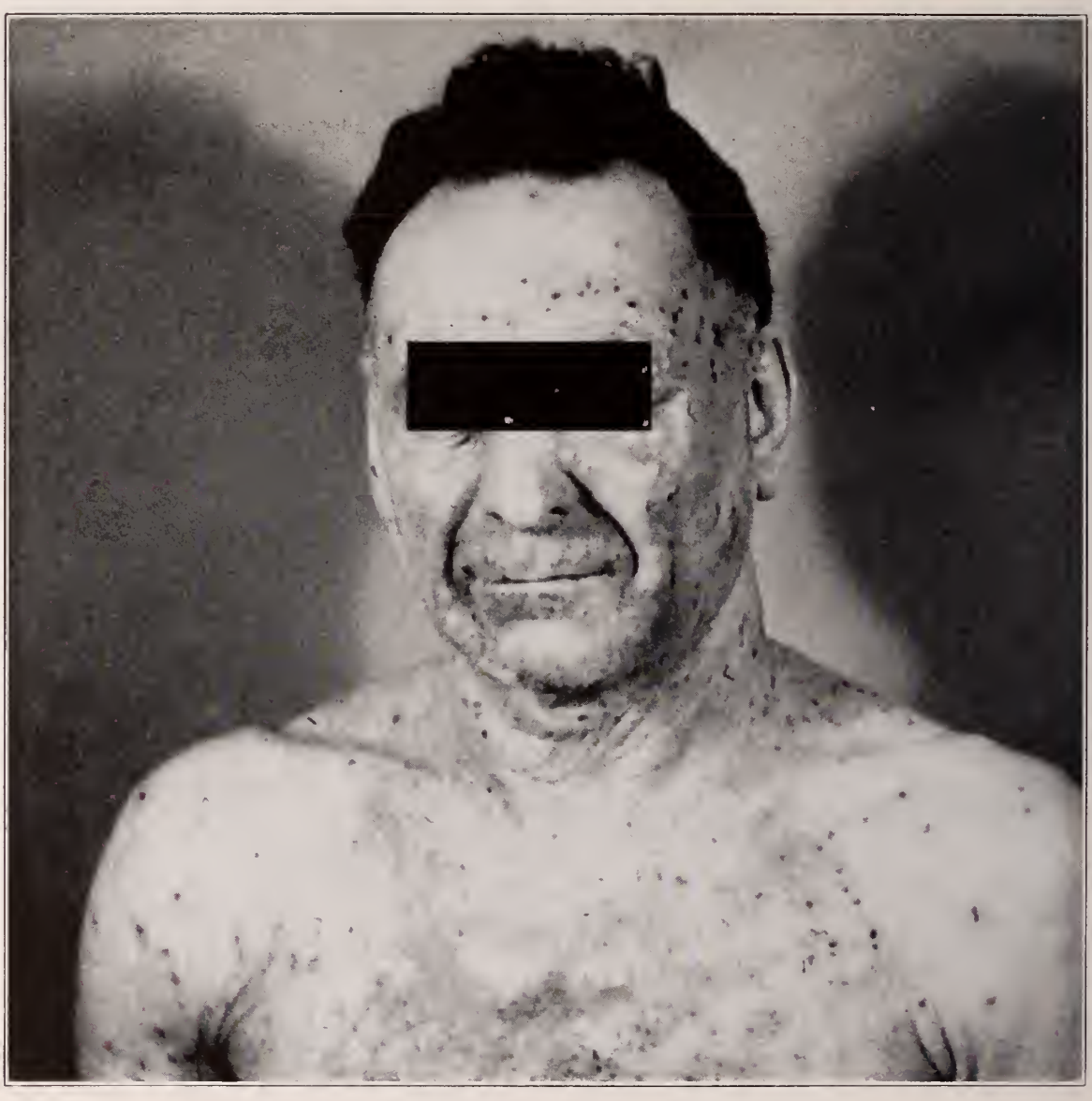

Fig. 2—Photograph taken five days after globulin injection.

amelioration of the eczema vaccinatum. This is a step forward in the establishment of specific, logical, and safe therapy. The following communication from Dr. C. Henry Kempe* is pertinent and is quoted in detail with his permission.

"We believe that vaccinia immune gamma globulin has an important place in the prevention and therapy of serious complications of smallpox vaccination and in the prevention of smallpox in the exposed susceptible contacts.

"We want to use this medium to contact teachers of public health, chiefs of service of contagion hospitals, pediatricians, and public health officers, in order to establish a good number of contacts throughout the country with physicians who might be apt to see such complications of smallpox vaccination. These complications are, in the main: (1) generalized vaccinia; (2) eczema vaccinatum; (3) progressive vaccinia (failure to produce specific antibodies) or vaccinia necrosum.

"It is our belief that three or four such complications might be expected in any large city per year and that between 20 to 60%

*Department of Pediatrics, University of California Hospital, San Francisco, California.

Fig. 3—Photograph taken at time of patient's release.

of them are fatal, despite intensive fluid and antibody therapy. It is clear that in many of these complications the doctor feels directly involved, since his judgment, in vaccinating the child in the first place, is open to question whenever serious complications occur.

"Vaccinia immune gamma globulin is a solution of the globulin component of human blood, collected from volunteer donors of the Armed Services who have been successfully vaccinated against smallpox from four to eight weeks prior to this blood donation. We found their neutralizing antibody titers to be maximal at that time. We have tested this material in India for the specific prevention of smallpox in exposed susceptible family contacts of smallpox cases. Our experience indicates that this material is effective in preventing the disease under such circumstances. Our clinical experience, in the prevention and treatment of serious complications of smallpox vaccination, has been more limited, but is promising.

"Our purpose here is to invite others to contact us by telephone or telegram when such cases are encountered in clinical practice, in contagious hospitals, in teaching centers, or in Health Department Well-Baby Clinics. Upon such contact we will ship, free

of charge, by air express, the required amount of vaccinia immune gamma globulin for early use. There is, at present, not enough material available to allow us to send vaccinia immune gamma globulin to health departments for storage.

"Dosage:

(1) Therapeutic dosage in the treatment of early cases of serious complications of smallpox vaccination: 0.3 cc./lb. intramuscularly. When the dose is greater than 10 cc. it may be divided, and given at separate sites to reduce the trauma of the injection.

(2) Prophylaxis: The exact dose remains undetermined. 0.03 cc./lb. is probably the minimal effective dose. Doses of 0.06 cc./lb. to 0.12 cc./lb. would probably give more effective protection. This material should be given as early as possible after exposure to a case of smallpox, and should *follow* smallpox revaccination (given in at least two, and preferably three, insertions on the arm) by 12–24 hours. The prophylactic use of this material in vaccination would be limited to children with eczema, where a sibling is being vaccinated and household contact could be expected. A child with eczema should never be vaccinated, *regardless* of whether the lesions are dry or wet. Our present experience indicates that this material has therapeutic value, even when the disease is in its third or fourth day, and it can generally be expected that no further lesions will crop out and that the existing lesions will involute quickly.

"It is our hope that this information will lead to wider knowledge of the availability of this special material, in order to add another therapeutic tool to our handling of illnesses caused by smallpox vaccination."

Summary and Conclusions

A case of eczema vaccinatum, including laboratory data and illustrative pictures, has been presented.

A commentary by Dr. C. Henry Kempe on the place of vaccinia immune gamma globulin in the prevention and therapy of serious complications of smallpox vaccinations and in the prevention of smallpox in exposed susceptible contacts has been presented.

In conclusion, it is felt that the use of specific therapeusis with vaccinia gamma globulin is indicated in the prevention and treatment of serious complications of smallpox vaccinations, particularly eczema vaccinata.

(M. J. F.) 324 East Wisconsin Avenue.

MEDICAL CONTINUATION COURSES TO BE PRESENTED AT THE CENTER FOR CONTINUATION STUDY, UNIVERSITY OF MINNESOTA

September 25–27	Pediatrics for Pediatricians
October 18–20	Techniques in General Practice
October 22–24	Gynecology for General Physicians
November 5–9	Radiation Therapy for Radiologists
November 19–21	Fractures for General Physicians

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

FISKE ESSAY ON INFERTILITY

The trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce as the subject for this year's dissertation "The Present-Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Cold Wave Dermatitis, Complications And Treatment*

By JAMES J. BARROCK, M. D.
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WOMEN spend approximately $3,000,000,000 every year for cosmetics in the United States, and the amount is still increasing. Millions of women have cold permanent waves regularly at home and in beauty salons each year, and the number of complaints with the use of these preparations is very small. Women are now able to produce permanent waves to the hair with this method, where formerly they were unable to obtain a curl with other methods. Cosmetics, in general, are among the least irritating substances used by the general public, but if unskillfully applied, they can produce a dermatitis to the scalp, forehead, face, etc. Schwartz and Peck[1] stated that hair waving and straightening probably cause more dermatitis than any other process.

The permanent wave solutions may contain organic, inorganic, or synthetic substances with an alkaline reaction — substances such as ammonium salts, carbonates, phosphates, thioglycolates, and aliphatic amines.

The chemical causes of dermatitis due to hair wave solutions are the alkalies, the resins, the preservatives, and the solvents. The chemicals producing the contact dermatitis are divided into primary irritants and sensitizers. A primary cutaneous irritant is an agent which will cause dermatitis by direct action on the normal skin at the site of contact if permitted to act in sufficient intensity or quantity for a long period of time. Very few primary irritants are used in modern cosmetics; some of those used are the alkaline substances and the solvents. A cutaneous sensitizer is an agent which will not cause any cutaneous changes on first contact but will produce specific changes in the skin a week to several months following exposure to the resins and preservatives in low concentrations. Further contact on the same skin or other parts of the body with the sensitizer will produce a dermatitis. The concentrated hair waving solutions may produce dermatitis more often than the diluted solutions. Most of the dermatoses caused by cosmetics are due not so much to the irritant properties of the cosmetics but to the fact that the persons affected are or have become sensitized to the cosmetics after repeated application.

The method for permanent waving of the hair consists of washing the hair, rinsing and drying the hair, and then applying a cold permanent wave preparation such as one of the thioglycolates or the alkalies. The reducing agents which swell the hair are usually inorganic sulfides in thioglycolates. The gums or resins may be karaya, acacia, sodium alginates, soluble shellac, gelatin, or casein. If the waving solution is accidentally spilled or drips onto the skin during application, absorbent cotton pads saturated with water are used freely, then neutralizer is used, and then plain water again. The person being given the cold wave will tell the beauty operator that she is experiencing a stinging, biting, itching, and burning sensation. When the operator is told of this discomfort, she should immediately stop the application of the cold wave solution or whatever solution she is applying and wash it off with repeated rinses of water to prevent a contact dermatitis from developing. She should not wait, as some operators do, until she has completed putting all of the hair in curlers.

Symptoms

Cutaneous eruptions on the scalp, face, etc., are due to the application of the thioglycolic acid solutions and usually have the characteristics of dermatitis venenata. These symptoms appear from within a few minutes to a few hours after exposure to the cold permanent wave solution, with a burning, itching, and stinging sensation of the scalp. The majority of cosmetic eruptions are seen as acute or subacute dermatitis characterized by erythema, mild to severe edema, vesicles, papules, oozing, crusting,

*Presented before the Metropolitan Dermatological Society, Chicago, November 9, 1955.

and excoriation. The edema will involve the scalp, the forehead, the eyelids, the infraorbital and supraorbital areas, the cheeks, the ears, the neck, and the nuchal area. The patient becomes restless and nervous, has a loss of appetite and weight, and is unable to sleep properly. Rarely do such chronic skin changes as lichenification, induration, fissuring, and hyperpigmentation take place.

Hyperpigmentation of the forehead occurred in one of my patients who had a severe contact dermatitis from a cold permanent wave preparation. A grayish pigmentation, which will unfortunately be permanent, developed on her forehead.

McCord, Stofer, and Williams[2] produced skin ulcers experimentally on rabbits following subcutaneous injections of thioglycolic acid. Simeone and Hardy[3] reported a case of chronic progressive infectious gangrene in a hairdresser who was exposed to cold wave solutions. McGill and Ray[4] reported 2 cases of dermatitis of the scalp allegedly due to the use of cold wave preparations. Gould[5] reported a case in which diffuse maculopapular eruption of the face and forehead occurred following the use of a home permanent.

A definite effect on the hair, such as fragmentation or breaking,[6] splitting, or loss of tensile strength and elasticity, may often be noted. The hair may become dry and lusterless and lose its sheen and softness. A change in the color of the hair may also occur; white hair may be darkened, for instance. Almost all cases of discoloration of the hair after waving are seen in women who have dyed hair.[7] An abnormal hair odor may be present. This may be due to the ammonium thioglycolate's having a prolonged contact with the scalp, the inadequate removal of the cold wave material after its effect has been achieved, or its incomplete neutralization. Pronounced thinning of the hair, giving the scalp the appearance of being "moth-eaten," may occur. We have observed this in many of our patients. The hair falls out with ease early in a cold wave dermatitis of the scalp, resulting in temporary alopecia areata.[8] Complications may develop due to the intense itching and burning sensations present.[9] The hair is matted together by the exuding serum and is difficult to comb.

Excoriations are the result of scratching and rubbing due to the pruritus present. Secondary infections such as impetigo contagiosa may develop. Conjunctivitis may occur if the solutions come in contact with the eyes. Caution should be exercised when applying the cold permanent wave solutions near the eyes, ears, nose, and mouth. Sataloff and Wilson[10] of Philadelphia recently reported a case in which a patient developed a perforated eardrum following the use of a home permanent wave. Some of the neutralizer accidentally ran into her left ear canal; and as a result of this accident, she now has a permanent loss of hearing of the left ear.

A fatality following the application of a permanent wave solution containing ammonium sulfide was reported in 1941.[11] Such solutions have now been discontinued. Most of the present-day solutions contain thioglycolate, which is less toxic. In 1947, Dunsky,[12] reported the accidental ingestion of a bromate cold wave neutralizer which resulted in the deaths of several children. Robertson, Flothow, and Kissen[13] later reported an attempted suicide by the ingestion of such a neutralizer (potassium bromate). Systemic symptoms such as muscular pains, headache, vertigo, nervousness, nausea, vomiting, oliguria,[14] anuria, nocturia,[15] albuminuria,[16] and anemia[17] have been reported as results of the toxic action of the cold wave solution.

The Manufacturer's Role

The manufacturer warns the operator of the toxic nature of the product by adequate labeling in large print and advises that caution should be exercised in the application of the cold permanent wave solution and the neutralizer. A trivial scratch may be the opening required, and no amount of warning on the package can eliminate the risk of development of dermatitis from an abrasion. McCord[18] has stated that prevention of a cosmetic dermatitis begins with the manufacturer of the product. One such manufacturer has done elaborate testing to find the degree of primary irritation of thioglycolic acid at various percentage levels and has found that no primary skin irritations occur at levels below 8%. McNally and Scull[19] claim that a cold permanent wave solution containing 6.5% ammonium thioglycolate is nontoxic. This has been due to the rigid control of the manufacturing procedure and

the ingredients used in the cosmetic preparations and has prompted many manufacturers to scrutinize their products. The directions of one company are not the same as those of a competitor. The majority of ill effects complained of are probably due to the misuse of the products because of the failure to heed directions or precautions. Despite repeated warnings of the manufacturer, the number of hairdressers developing cold wave dermatitis of the hands is increasing. The effects from the repeated prolonged contact with and exposure to the chemicals of cold permanent wave solutions bear no relation to allergy. Allergic responses to thioglycolates appear to occur rarely.[20] Allowances should be made for allergic responses to other ingredients such as wetting agents, perfumes, solvents, etc. It has been proved that a hairdresser who has developed dermatitis of the hands and painful finger tips due to exposure to cold permanent wave chemicals will find it difficult to handle and work with any materials of this profession.

Permanents should not be given if there are abrasions of the skin of the scalp or on the hands of the operator. If the operator's hands are chapped or if skin disease is present, the solutions will act as an irritant and cause severe dermatitis. Long after the dermatitis has healed, thioglycolic acid fumes in the beauty salon will, without the person's coming into actual contact with the solution, produce a severe dermatitis again. If the operator handles cold wave solutions daily, he or she should wear rubber gloves[21] and a rubber apron until the wave is completed. The hair must be thoroughly shampooed and rinsed before applying the cold waving solutions. A cold wave permanent should not be given if the hair has been recently bleached or tinted or if a previous permanent remains. Operators are instructed to ask clients about previous experiences with cold waves.

Prevention of Contact Dermatitis

A dermatitis of the operator's hands can be avoided by his wearing clean rubber gloves and impervious sleevelets each time a hair treatment is given. Surgeons' gloves made of fine latex or plastic will not hamper the operator's dexterity. New gloves and sleevelets should be worn for each patron. The gloves can be disinfected by immersion in a germicidal solution such as 10% liquor cresolis compound for approximately 10 to 15 minutes. Operators with delicate skin should use superfatted sulfonated oils and soap* instead of soaps which defat the skin when cleansing the hands. Before retiring, the operator should apply a good emollient cream containing animal or vegetable oils; and he should wear cotton gloves while sleeping. Beauty operators who are anemic should avoid contact with permanent wave solutions.[17]

Patch Test

In patch testing,[22] the patient should be tested adequately with all the materials that have been used in the entire technique of the cold waving process; namely, the preliminary shampoo material, the preliminary cleansing lotion, the cold wave material, the neutralizer or oxidizing agent, the post-treatment shampoo material, the wave setting material, perfumes, etc. Patch tests for sensitivity to thioglycolic acid have proved unreliable; a negative patch test does not exclude the irritant as the causative factor. Downing[23] obtained positive patch tests with ammonium thioglycolate lotion in 24 patients. The sensitivity may be due to the combined effect of the softener, the fixer, and the keratin of the hair. The skin should be tested with single ingredients and combinations of two or more ingredients after the dermatitis has subsided.[24] All cosmetics used by the patient should be recorded. Patch tests must be performed by competent dermatologists. These tests must be made on normal skin in a manner simulating that in which the suspected cosmetic or solution was used. Contact tests[25] of all materials used can be applied to the flexural surface of the forearm of the patient one to two months after the lesions have healed. The manufacturer of cosmetics should be willing and ready to supply test kits and specifications or ingredients to the physician for patch testing. The principal difficulty here is that the manufacturer wishes to maintain secrecy regarding the formula of his product in order to protect his cosmetic from competition.

Treatment

The treatment is usually a simple procedure since the eruption is of external origin. The majority of patients improve rapidly

*Basis soap (Duke), Oilatum (Stiefels), Lowilla (Westwood)

once the contactant is removed. The dermatologist must make sure that the etiology is established and must be emphatic that the patient avoid further contact with the causative agent. Cortisone or Corticotropin is beneficial for the first few days in the acute stage. Cool to lukewarm dressings are indicated in acute stages of the eruption. Hot, wet dressings are advocated when secondary infections are present. Antiseptics, antihistaminic ointments, penicillin, sulfonamides, local anesthetics, tars, sulfurs, or mercurials should not be used as they may add further irritation to the existing dermatitis. Open wet dressings are better than covered wet dressings. They should not be left on too long as they will produce a maceration of the tissues. Lotions are helpful when applied after the acute symptoms have subsided, or they may be used between dressings. If they are too drying, an emulsion may be more soothing. Ointments are used for healing as well as absorbing agents. Bland oils such as olive oil, liquid petroleum, or the sulfonated oils* should be used to cleanse the skin because soaps act as an irritant to an already inflamed skin. Antibiotics used for wet dressings or as ointments are permissible only when a secondary infection is present. The best management for all cases of contact dermatitis, once the irritant has been removed, is use of simple soothing treatments of lotions or mild ointments.

Summary

1. Cold wave solutions are used extensively, and the frequency of reactions reported is less than 0.1%.[22] These reactions are characterized by varying degrees of primary irritations.
2. Dermatitis of the hands is more frequent in the beauty operator than in the patron of the beauty salon.
3. Commercial preparations used in beauty salons contain approximately 7% ammonium thioglycolate and a sufficient excess of ammonia to bring the pH to 9.0 to 9.5.[26]
4. Allergic responses to the thioglycolates are rare.
5. Cold wave permanent solutions act by softening the hair so that it will curl. The neutralizing agents stop the softening at a certain point, thus maintaining the "curl" or wave. Perfumes may be added to cold wave solutions for aesthetic reasons.
6. Most instances of dermatitis or skin reaction to cold wave solutions are due to use of cold waves without meticulously following the directions or cautions of the manufacturer. Occasional reactions are due to previous abrasions or minute cuts in the scalp or on the hands or, more infrequently, to an individual sensitivity of the patron. Once dermatitis has developed, a dermatologist should be consulted to be sure that the reaction does not spread and to determine what the patron may do to prevent recurrence of the skin irritation.
7. In the case of operators who may be exposed daily to varying amounts of the waving solution, protection of the hands is essential, as a severe incapacitating dermatitis may develop as a result of sensitization.

*Acidolate (White Laboratories, Inc.)

425 East Wisconsin Avenue.

REFERENCES

1. Schwartz, L., and Peck, S. M.: Cosmetics and Dermatitis, New York and London, Paul B. Hoeber, Inc., 1946.
2. McCord, C. P., Stofer, B. E., and Williams, P.: Action of thioglycolic acid and thioglycolates on animals after subcutaneous introduction, Indust. Med. 16:62–65 (Feb.) 1947.
3. Simeone, F. A., and Hardy, H. L.: Chronic progressive infectious gangrene of skin; patient with exposure to cold wave solution, Ann. Surg. 128: 1112–1123 (Dec.) 1948.
4. McGill, C. M., and Ray, L. F.: Cold wave dermatitis; report of 2 cases, Indust. Med. 16:238 (May) 1947.
5. Gould, A. V., Jr.: Eruption following home permanent, J.A.M.A. (Queries and Minor Notes Section) 143:1128 (July 22) 1950.
6. Bellach, H.: Effect of home permanent wave preparations (ammonium thioglycolate and potassium bromate) on hair, Connecticut M. J. 14:-405–411 (May) 1950.
7. Brunner, M. J.: Medical aspects of home cold waving, A.M.A. Arch. Dermat. & Syph. 65:316–326 (March) 1952.
8. Reiches, A. J., and Lane, C. W.: Temporary baldness due to cold wave thioglycolate preparations, J.A.M.A. 144:305–306 (Sept. 23) 1950.
9. Sawicky, H. H., and Kanof, N. B.: Temporary hair loss following cold waving with thioglycolate preparations, New York J. Med. 52:1175 (May 1) 1952.
10. Sataloff, J., and Wilson, J. F.: Perforated ear drum following home permanent wave, J.A.M.A. 147:1135–1136 (Nov. 17) 1951.
11. Bunce, A. H., Parker, F. P., and Lewis, G. T.: Accidental death from absorption of heatless permanent wave solution, J.A.M.A. 116:1515–1517 (April 5) 1941.

12. Dunsky, I.: Potassium bromate poisoning, Am. J. Dis. Child. 74:730–734 (Dec.) 1947.
13. Robertson, H. F., Flothow, M. W., Jr., and Kissen, M. D.: Potassium bromate poisoning; report of case, J. Pediat. 36:241–243 (Feb.) 1950.
14. Kitto, W., and Dumars, K. W.: Potassium bromate poisoning, J. Pediat. 35:197–200 (Aug.) 1949.
15. Edwards, W. M., and Leedham, C. L.: Potassium bromate poisoning incident to ingestion of "cold wave" neutralizer, Hawaii M. J. 11:362–365 (July–Aug.) 1952.
16. Thompson, H. C., and Westfall, S. W.: Potassium bromate poisoning; report of case due to ingestion of "cold wave" neutralizer, J. Pediat. 34:-362–364 (March) 1949.
17. Cotter, L. H.: Thioglycolic acid poisoning in connection with "cold wave" process, J.A.M.A. 131:-592–593 (June 15) 1946.
18. McCord, C. P.: Toxicity of thioglycolic acid used in cold permanent wave process (Comment on Cotter's article), J.A.M.A. 131:776 (June 29) 1946.
19. McNally, W. D., and Scull, R. H.: Thioglycollate cold wave process, Arch. Dermat. & Syph. 57:-275–278 (Feb.) 1948.
20. McCord, C. P.: Physiologic properties of thioglycolic acid and thioglycolates, Indust. Med. 15:-669–676 (Dec.) 1946.
21. Goodman, H.: Dermatitis from cold wave permanent chemicals; random thoughts on new source of difficulty, Urol. & Cutan. Rev. 49:117–119 (Feb.) 1945.
22. Goldman, L., Mason, L., and McDaniel, W.: Permanent wave process; clinical report with special reference to effect of ammonium thioglycolate on skin, J.A.M.A. 137:354–357 (May 22) 1948.
23. Downing, J. G.: Dangers involved in dyes, cosmetics and permanent wave lotions applied to hair and scalp, A.M.A. Arch. Dermat. & Syph. 63:561–564 (May) 1951.
24. Behrman, H. T., Combes, F. C., Weissberg, G., Mulinos, M. G., and Hurwitz, M. M.: Cold permanent hair-waving process; dermatologic and clinical study, J.A.M.A. 140:1208–1209 (Aug. 13) 1949.
25. Howell, J. B.: Contact dermatitis from cold permanent waving, Arch. Dermat. & Syph. 49:432 (June) 1944.
26. Lehman, A. J.: Health aspects of common chemicals used in hair-waving preparations; Committee on Cosmetics, J.A.M.A. 141:842–845 (Nov. 19) 1949.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

The first-prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held at the Hotel William Penn, Pittsburgh, May 6–9, 1957.

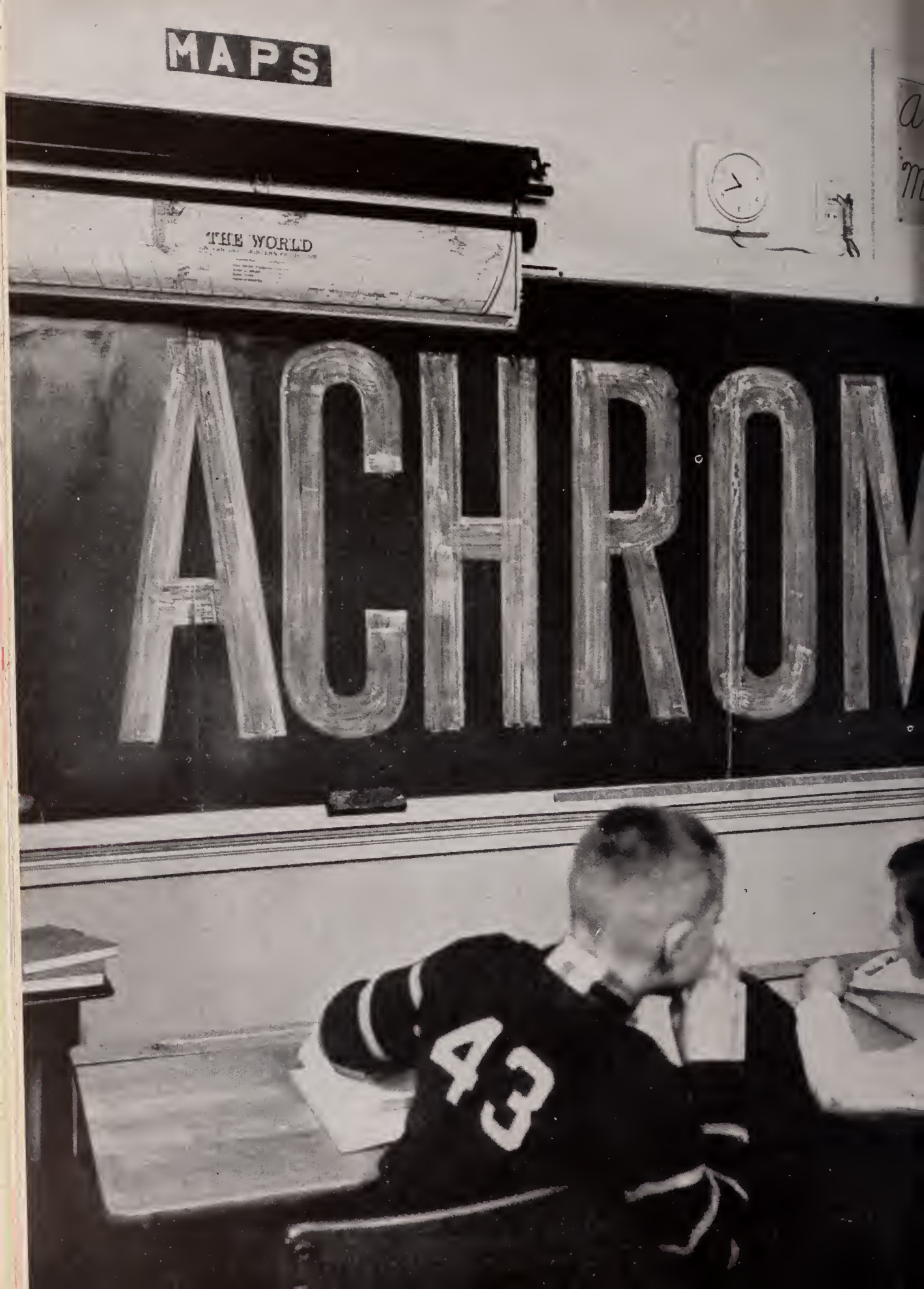
For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association, which will be held in the Hotel Statler, New York, May 28, 29, and 30, 1957, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the association.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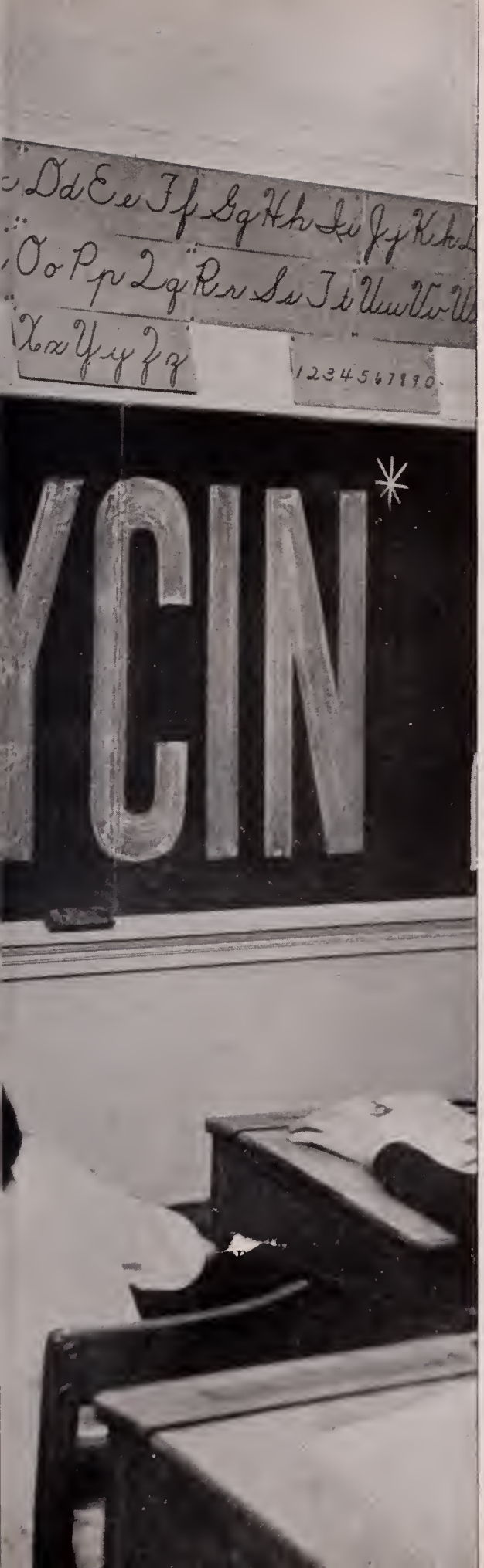

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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The Commonly Used Toxic Solvents*

By LOUIS W. SPOLYAR, M. D.**
Indianapolis, Ind.

Introduction

THE number of solvents used in industry is large, and their toxic effects are manifold. It is not feasible for me to deal with them individually here. I will accordingly limit my discussion to a review of the physiologic principles that govern the action of solvents in low concentration. Familiarity with these principles is necessary for early detection of body changes before organic damage occurs.

Since solvents exert a vapor pressure at ordinary room temperatures, they are volatile. Thus, they are readily inhaled and readily absorbed. Because the lungs offer a capillary surface of 100 square meters, absorption of as much as 70 to 90% of the inhaled solvent is assured.[1]

The rate of absorption of the inhaled solvent will depend on its solubility and on its concentration in the blood and tissues. It is known that as long as the blood passing through the pulmonary capillary bed is not saturated with the inhaled solvent, it will continue to take up more and more solvent until the partial vapor pressure of the solvent is the same on both sides of the diffusing membrane and a state of equilibrium is reached.

Signs of Solvent Absorption

However, before equilibrium is reached, certain measurable vascular changes will occur. Foulger has conclusively demonstrated that the most easily detectable sign of solvent absorption is an increase in diastolic blood pressure when arterial blood pressures are taken under standard sitting conditions. Under such circumstances, diastolic blood pressure will rise to 90 or 100 mm. with no increase of systolic blood pressure, thus decreasing the pulse pressure. This all occurs without any other clinical evidence of solvent poisoning.

Pulse pressure serves as an indication of the needs of the viscera or muscles for blood. A high pulse pressure indicates, roughly, that a major portion of the total blood supply is shunted to large muscle masses. A low pulse pressure indicates a decreased blood supply to the muscles and an increased supply to the viscera. Therefore, in cases of exposure to solvents, in which conditions of low pulse pressure are observed, the blood supply to the muscles is decreased with a resultant deficiency of oxygen to muscle fibers, manifested clinically by undue fatigue and by lack of muscle tone, especially in the lower extremities and abdominal wall. The lack of muscle tone may be reflected by a low venous return to the right heart; and unless this is balanced by an increase in the pulse rate, a decreased cardiac output may ensue. With this poor venous return, signs of dizziness and early syncope may be seen. If exposure is prolonged and increases in severity, shock may occur.

Such abnormal physiological changes are often present for months before special organ damage can be detected. Eventually, there may be specific organ damage; and evidence of classic poisoning by the particular chemical is then observed. The organ damage is, in all probability, due to local tissue hypoxia caused by protracted abnormal vascular changes.

Prevention of Specific Organ Damage

Thus, we do have a period when the early effects of poisoning can be detected and measures instituted that will protect the exposed workers from developing organic damage. Once the controls are instituted and temporary removal from exposure is attained, the reverse physiological reaction will take place. The concentration of solvent in the blood will decrease when solvent vapor pressure is lower in the air spaces. The diastolic blood pressure accordingly increases, and the blood flow returns to normal with complete recovery of the patient. The reversibility of this reaction is of great importance in treatment and prognosis of such cases.

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*Read before Industrial Health Clinic, Milwaukee, Wisconsin, January 12, 1956.

**Director, Division of Industrial Hygiene, Indiana State Board of Health.

The usual symptoms given by most workers exposed to solvents, before specific organ injury occurs, are unusual fatigue, lassitude, headaches, gastrointestinal disturbances, dizziness, numbness of extremities, and dyspnea on slightest exertion. These symptoms are listed in the order of their appearance as exposure to solvents continues. The symptoms are due to hypoxia of the large muscle masses that results from the shunting of most of the blood to the abdominal organs.

Such symptoms are not specific for solvent absorption but are found also in many other conditions such as infections, poor nutritional states, and neurasthenia. The possibility of exposure to solvents should be thoroughly explored in all cases of industrial workers with these complaints when no other explanation is found.

If a history of exposure to solvent is obtained, one should not conclude that a serious poisoning by that solvent has occurred. As Foulger[1] has so well stated, "A definite statement on the part of a physician that such and such a chemical has poisoned the patient will do nothing to allay alarm. It may often introduce a serious psychic factor into the picture, a factor which no amount of subsequent discussion can entirely remove. The better plan is to advise the patient carefully on proper use of the materials involved, to assure him or her that a few weeks without exposure will lead to complete recovery and in the meantime to prescribe adequate rest, proper nutrition and proper, but not excessive, recreation in the open air. If the patient is the operator of a small business using solvents, the physician can do much by advice about hygienic working conditions. Such advice appears much more practical and is deprived of a purely 'philosophic' atmosphere by a visit to the place of business, where the physician can observe working conditions and discuss improvements."

The taking of blood pressures and plotting of diastolic pressures is a simple, practical, easily performed, preventive medical technique for protecting the health of workers exposed to solvents. It permits the early detection of physiological changes long before the occurrence of classical poisoning and tissue destruction. If the diastolic pressure rises, the employee should be removed from the exposure or, preferably, the job should be controlled, or both.

Effects of Solvents on Skin

Solvents have an adverse reaction on the skin in that they may defat the derma and thus produce a dry, cracked skin. The defatting action removes the so-called "acid mantle of protection," the fatty secretion that is our first line of defense against bacterial infection. Once this protective film is removed, skin infections are likely to develop either from growth of the normal resident bacterial flora or from action of secondary invaders. If solvents come in contact with the skin under occlusive clothing, a severe burn similar to the ether burn formerly seen with cone anesthesia will result. This observation points up that care must be exercised when patch testing is resorted to; severe burns can be produced if occlusive tests are used without proper precautions. Before undertaking patch tests it is well to review the technique, particularly with respect to dilutions, in a standard textbook of dermatology.

Maximum Allowable Concentrations of Solvents

It is apparent that there is no such thing as a completely safe solvent. All are capable of producing abnormal early physiological changes, and some may eventually produce specific organ injury. This does not mean that solvents cannot be used, but it does mean that they should be used under controlled conditions and at atmospheric levels with not over the usually accepted maximum allowable concentrations. Such values are published annually by such groups as the American Standards Association and the American Conference of Governmental Industrial Hygienists. The values are given as so many parts solvent per million parts of air. To most of us such figures are meaningless, for it is difficult for us to translate them to known or frequently used measures. Following Sterner's[2] original demonstration, I asked our laboratory director to translate these figures to the number of milliliters of solvent that would equal the maximum permissible limit if the solvent were uniformly vaporized in a room 10 feet by 10 feet by 10 feet. By referring to table 1, you will note that it takes 2.8 cc. of carbon tetrachloride and 84.5 cc. of petroleum naphtha to approach their respective maximum allowable concentrations. The difference between 2 cc. and 84 cc. is quite large; therefore,

everything else being equal, a solvent with the highest permissible limit should be used since it has the greatest margin of safety.

Table 1

Solvent	Maximum Allowable Concentration in p.p.m.*	Volume of Substance Needed to Reach Maximum Allowable Concentration in Room 10′ x 10′ x 10′**
Carbon Tetrachloride	25	2.8 cc.
Isophorone	25	4.32
Benzene	35	3.57
Chloroform	100	9.25
Dioxane	100	9.85
Ethylene Dichloride	100	8.96
Amyl Acetate	200	34.6
Cellosolve	200	22.4
Coal Tar Naphtha	200	25.8
Methyl Alcohol	200	9.36
Tetrachloroethylene	200	23.6
Toluene	200	24.5
Trichloroethylene	200	20.9
Xylene	200	28.2
Methyl Ethyl Ketone	250	25.8
Ether	400	48.2
Gasoline	500	84.5
Hexane	500	75.5
Methyl Chloroform	500	58.3
Methylene Chloride	500	36.8
Petroleum Naphtha	500	84.5
Stoddard Solvent	500	69.0
Acetone	1,000	84.6
Ethyl Alcohol	1,000	68.1

*Maximum allowable concentration values as established by American Conference of Governmental Industrial Hygienists, 1955.
**Assumes complete volatilization and equal distribution throughout the area.

Carbon Tetrachloride

Let us consider some specific practical observations on a few commonly used solvents. In spite of its extreme toxicity, large quantities of carbon tetrachloride are still used in either old or new applications. For example, it is commonly used as a general solvent, electric motor cleaning agent, or additive to insoluble cutting oils. In each instance, carbon tetrachloride should not be used. Safer substitutes are available. Tri- and perchloroethylene, as well as various methyl chloroform compounds, are safer general degreasers. Various substitute electric motor cleaners have been developed to replace carbon tetrachloride. If carbon tetrachloride must be used, it is mandatory that good, well-designed engineering and medical controls are installed. One cannot trust to luck in handling this solvent. The odor threshold is about 80 p.p.m., yet carbon tetrachloride is extremely toxic in values below this. The maximum allowable limit is 25 p.p.m. The use of carbon tetrachloride in industry and in the home should be discouraged.

Trichloroethylene and Perchloroethylene

The question of whether smoking should be permitted in areas where trichloroethylene is used is frequently asked physicians. In general, there is a fear of phosgene poisoning. Studies done by Little[3] show that the temperature at the glowing tip of a cigarette is about 950 C. At this temperature trichloroethylene can be converted to phosgene, yet actual tests show no phosgene is present when the vapors are drawn through the cigarette. Phosgene does develop under such conditions, but it is combined with the tars in the cigarette and does not go through and therefore does not get into the respiratory tract.[3] Thus, there is no practical reason to prohibit smoking, just to prevent phosgene poisoning, in areas where trichloroethylene is used.

Trichloroethylene and perchloroethylene are commonly used degreasing agents in industry. In spite of their widespread use, the average physician has little personal knowledge as to how such degreasers are actually used. For that reason an explanation is indicated. In describing such operations, patients may give the physician the erroneous impression that they always inhale high concentrations of hot vapors. Actually, trichloroethylene is brought to boil at a temperature of 188 F. in a specially designed condensing tank. The solvent is heated, and the vapor rises toward the top of the tank; but before the top is reached, the vapor contacts a cold zone of air produced by a cool water jacket. On striking this cool zone, the vapor is condensed and is dropped back into the liquid zone. The parts to be degreased are placed and held in the vapor zone. Under such operation, vapors will not escape unless the water temperature is too warm or heat input too high. Since thermostats regulate both of these points, such failures are not likely to occur.

Should the tank be out of thermal balance, irritation of the eyes and mucous membranes by the escaping trichloroethylene vapors will be noted when concentrations exceed 500 p.p.m. Such a tank should be serviced.

In my opinion, addiction to trichloroethylene can occur. Men will frequently inhale its vapors for the lift it gives them.

Summary

Search for and proper interpretation of the early vascular changes produced by repeated small inhalations of solvents will reveal the need for early medical and engineering control measures that can prevent the occurrence of classical organ damage. This, in my estimation, is good preventive industrial medicine and is a true medical service to industry.

1330 West Michigan Street.

REFERENCES

1. Foulger, J. H.: Physiologic effects of industrial solvents, J.A.M.A. 139:826–829 (March 26) 1949.

2. Sterner, J. H.: Industrial Exposures to Volatile Solvents, Scientific exhibit, 1941 meeting, American Association of Industrial Physicians and Surgeons, Hotel William Penn, Pittsburgh, Pa.

3. Little, J.: Formation of phosgene by action of hot surfaces and its absence when tobacco is smoked in atmospheres containing chlorinated hydrocarbon vapours, Brit. J. Indust. Med. 12:304–308 (Oct.) 1955.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	12:15 p.m.
WHSA	Brule	Friday	10:30 a.m
WHKW	Chilton	Friday	10:30 a.m
WCHF	Chippewa Falls	Saturday	9:45 a.m.
WHWC	Colfax	Friday	10:30 a.m
WHAD	Delafield	Friday	10:30 a.m
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Friday	10:30 a.m
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	5:00 p.m
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	1:00 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Friday	10:30 a.m
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:45 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Friday	10:30 a.m
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	11:00 a.m.
WBKV	West Bend	Saturday	11:15 a.m.
WHLA	West Salem	Friday	10:30 a.m

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

The Symptomatic Treatment of Bronchial Asthma

Allergic reaction in the tissues of the bronchial tree gives rise to an inflammatory lesion which is characterized by edema and hyperemia of the entire wall of the bronchus, stasis of lymph, hypersecretion of mucus, and a certain degree of muscular contraction. These changes and their effects on the respiratory pattern result in the clinical picture of asthma. Attacks which are mild and of brief duration usually are uncomplicated; but as they increase in severity and duration, a secondary infectious bronchitis develops which further aggravates the respiratory symptoms. As the patient labors for breath, fluid and food intake are often decreased while fluid and nutritional needs are increased. Dehydration, depletion, and exhaustion rapidly result; and if the obstruction to breathing is severe, hypoxia and carbon dioxide retention occur.

Clinical management of asthma requires the judicious use of drugs for the correction of the disease *per se*, as well as correction of the complications. Drugs which are in current use for the treatment of uncomplicated asthma are listed in the following table in order of relative effectiveness, beginning with the least effective.

Drug	Effectiveness	Actions	Comment
Antihistamines	Questionable	Block histamine	
Oral aminophylline	Questionable	Bronchodilatation	Adequate dosage cannot be given orally
Inhalations of epinephrine or its derivatives	Slight	Vasoconstriction Bronchodilatation	Valuable for immediate effect
Oral ephedrine	Slight	Vasoconstriction Bronchodilatation	Usually combined with sedatives
Rectal aminophylline	Moderate	Bronchodilatation	
Subcutaneous epinephrine	Marked	Vasoconstriction Bronchodilatation	Brief effect
Intramuscular epinephrine in oil	Marked	Bronchodilatation Vasoconstriction	Long-acting
Intravenous aminophylline	Marked	Bronchodilatation	
Steroids—ACTH or prednisolone	Marked	Anti-inflammatory	Of little value for immediate attack but marked benefit with prolonged use
Iodides	Marked	Promote secretion of more fluid mucus	

These drugs relieve the bronchial obstruction and improve respiratory exchange, but successful treatment may not be realized unless the complicating factors also are considered. Adequate rest, nutrition and fluid intake are of major importance; and if they cannot be obtained naturally, judicious use of sedation and parenteral fluids is indicated. Antibiotics should be employed when evidence of secondary infection exists. Oxygen may be of value in the presence of acute hypoxia but should be used with care if long-standing respiratory insufficiency is present.
—SEYMOUR B. CREPEA, M. D.

FALL MEETING OF WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY—OCTOBER 27, 1956

The fall meeting of the Wisconsin Society of Obstetrics and Gynecology will be held at Wisconsin General Hospital, Madison, on Saturday, October 27. Dr. Alice Watts, Milwaukee, president, announces that starting at 8:00 a.m. there will be an operative clinic, and this will be followed by scientific papers.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: M. B. Llewellyn, M. D.

Presentation of Case*

History

A 54-year-old white male was admitted to the hospital because of severe chest pain. The patient stated that he felt well when he arose that morning but about 7:30 a. m., while leaning forward, he developed a sudden, heavy, pressure-type pain beneath the upper substernum radiating to the mid-dorsal spine, neck, and jaw. There was also some radiation into the arms with a feeling of weakness in the arms. The pain was very severe and continuous with some waxing and waning of severity. Salivation and lacrimation occurred at the height of pain, and a feeling of air hunger was present from the onset. There were no associated gastrointestinal symptoms, and diaphoresis was not present. Shortly after the onset the patient was seen at home, where he was found in a sitting position, groaning with pain. A carefully obtained history revealed no evidence of anginal pain prior to this illness. Fifteen milligrams of morphine by hypo gave him little relief, and he was moved to the hospital.

Although he had no history of a primary lesion, he had had a positive Wassermann test in 1941 and had been treated for syphilis for approximately two years with intravenous and intramuscular injections. A spinal fluid Wassermann had been negative in 1946, and in 1953 a quantitative serological test for syphilis had been positive with undiluted serum only. For many years the patient had been bothered with a recurrent duodenal ulcer, which perforated in 1940; and he finally had a gastric resection in 1949 with good results. Other problems included chronic alcoholism, recurrent urethral stricture, and median bar hypertrophy of the prostate corrected by transurethral resection in 1953. Prior to the present admission the blood pressure had been within normal limits. The family history was not contributory.

* From Mercy Hospital, Janesville.

Physical Examination

At the time of admission the patient preferred to sit; and, in spite of morphine medication, he was in moderately severe pain. He appeared pale, and the skin was cool and dry. The blood pressure was 200/110, and the pulse rate was 84 to 88 and regular. The neck was negative, and the peripheral lymph nodes were not palpable. The heart rhythm was regular. The cardiac border was percussed near the left anterior axillary line. A sighing diastolic murmur was heard immediately after the second sound with greatest intensity to the left of the sternum. The murmur was heard also in the aortic area. The lungs were clear to percussion and auscultation. The abdomen was negative except for surgical scars. The femoral pulsations were normal.

Laboratory Data

Hemoglobin 12.9 gm., 83.2%; red blood cells 4,130,000; white blood cells 7,650 with 59% neutrophils including 6% band forms; 2% eosinophils; 35% lymphocytes; and 4% monocytes. The sedimentation rate was 38 mm./hr.; and urinalysis revealed one plus albumin, specific gravity 1.020, and many white blood cells with clumps. The Kahn test was negative. Five days after admission the sedimentation rate rose to 83 mm./hr. A chest x-ray showed enlargement of the left ventricle and tortuosity of the ascending aortic arch, causing widening of the superior mediastinal shadow. Arteriosclerotic changes were noted in the transverse aortic arch and in its descending portion. The lung fields were essentially clear. The electrocardiogram on the day of admission revealed a horizontal heart. Repeated tracings during the early hospital course showed no change.

Hospital Course

The day after the patient's admission to the hospital the diastolic murmur heard at the initial examination was very much softer, and the blood pressure had dropped

to 110/70. It is interesting that despite many examinations prior to this illness, a diastolic murmur had never been reported. The murmur persisted for four days and then became inaudible. During his early hospitalization the patient looked very ill; and he required repeated doses of morphine, which gave only partial relief for his pain. The blood pressure stabilized around 100/60. Sixteen days after admission a loud pericardial friction rub was heard in the lower sternal and mitral regions. The friction sounds seemed to be accentuated during inspiration. At this time the blood pressure was 100/60. The following day the friction rub was still present but less intense. Eighteen days after admission and two days after the appearance of the pericardial friction rub, sudden collapse of the patient following a low enema occurred. His pulse rate rose to 140 per minute, and his blood pressure fell to 70/0. An electrocardiogram taken at this time showed a posterior myocardial infarction.

The patient required continuous oropharyngeal oxygen, and a satisfactory blood pressure was maintained only by the use of intravenous norepinephrine drip. A few days later it was possible to discontinue the norepinephrine, and the blood pressure stabilized between 90 and 100/70. The pulse rate varied from 100 to 120 per minute. Anticoagulant therapy was started after the patient's collapse on the eighteenth hospital day. Throughout his illness he was treated with strict bed rest and moderate back-rest elevation. Much of the time he required oxygen. Four weeks after admission he was digitalized without much benefit. During the early part of the hospital stay he had a low-grade fever, and repeated urinalyses demonstrated pyuria. Tetracycline, 250 mg., four times a day was given early in the hospital course, but the pyuria persisted.

Five weeks after admission the patient complained of numbness of his thighs and legs and of inability to move his lower extremities. Femoral pulsations were absent, and the lower extremities were cold and white. He expired suddenly five and a half weeks after admission.

Clinical Discussion

Dr. E. H. Betlach, Radiologist: As the protocol has indicated, the admission bedside film shows enlargement of the left ventricle and marked tortuosity of the entire aorta with widening of the ascending aortic shadow. Arteriosclerotic plaques are seen in the transverse and descending aorta. The superior mediastinum above the level of the aortic arch is normal, and the lung fields are essentially clear. Progress films in the department 10 days later, after the patient's condition had improved somewhat, reveal again the enlarged left ventricle and the sclerotic plaques as well as the tortuous descending aorta. The ascending aorta is less prominent, and no localized sacular or fusiform enlargement of the aorta is present. There is no sclerosis of the ascending aortic arch. None of the ribs show evidence of notching, and the vertebral bodies are intact. A comparison of these films with earlier films taken in 1947 and 1951 shows no change except the left ventricular enlargement.

Dr. G. E. Gutmann: Is there any indication that the configuration is that of hypertension or of aortic insufficiency? From what I see, it is more a heart of hypertension than of aortic insufficiency.

Doctor Betlach: In both aortic insufficiency and hypertension the left ventricle dilates and eventually hypertrophies, with a corresponding elongation of the aorta. I do not believe that in this case it is possible to say that the silhouette is characteristic of either of these specific entities. I believe that the enlargement of the left ventricle is probably due to dilatation.

Dr. T. O. Nuzum, Internist: There are two ways of approaching this case. One would be, since we have the whole picture, to consider it in retrospect; the other would be the way in which the clinician approached it, beginning with the presenting symptoms. We'll consider it by the latter method. The history of chest pain would lead one to think primarily of a coronary occlusion and the various conditions which produce chest pain simulating coronary occlusion. These are many, and we will mention the most impor-

tant. One could consider symptoms referable to hiatus hernia with sudden extension of or protrusion of the stomach into the chest cavity. One could think, also, since this man had a duodenal ulcer with a gastric resection, of some complication of this, possibly a pancreatitis, which could simulate a coronary occlusion. But we are told in the history that there were no abnormal abdominal findings, so we will not consider these further.

One thing which must be considered very seriously in addition to a coronary occlusion is the presence of a dissecting aneurysm of the aorta. The history is very suggestive of that, particularly the nature of the pain, its reference, and the fact that it was not relieved by repeated doses of morphine, plus atropine and oxygen. One would expect that in a patient with a coronary occlusion who was given adequate morphine and oxygen, the pain would be relieved. Also in favor of dissecting aneurysm is the fact that the man had a very high systolic pressure, 200, and diastolic, 110. His chest x-ray showed evidence of sclerotic changes in the arch of the aorta, and he had a past history of a positive Wassermann. I am not able to decide whether or not this might have been a false positive Wassermann. If it was a true positive Wassermann, it might have some bearing on the sclerotic changes in the aorta. It also might have some bearing on the condition of the aorta relative to a possible dissecting aneurysm.

From the history I would judge that this man did not have a coronary artery occlusion at the time of his admission to the hospital. I would think that coronary occlusion developed from the sixteenth to the eighteenth day, at the time a pericarditis with a pericardial friction rub was manifested. The electrocardiogram, which previously had shown only evidence of left ventricular hypertrophy and a horizontal heart, now showed evidence of an acute coronary occlusion. From this, I would think that the coronary occlusion and myocardial infarction developed about the sixteenth to the eighteenth day, and that the process for which the patient was admitted originally was not due to myocardial infarction.

Now, to go back again; the man had hypertension. From the history we understand that in 1953 his blood pressure was normal and had been normal on repeated determinations previously; but now in 1955, two years later, this 54-year-old man had a rather marked hypertension. One has to consider the various causes of hypertension which might intervene in a two-year period. There was a history of repeated findings of clumped pus cells in the urine, which would indicate infection in the urinary tract, and would lead one to think of a chronic pyelonephritis as being implicated in the hypertension. Also to be considered would be a unilateral kidney lesion of the Goldblatt type with hypertension developing. To be considered, too, is a pheochromocytoma with development, rather acutely, of severe hypertension. We have no positive findings. We have no x-ray studies of the genitourinary tract on which to base any diagnosis, so we merely mention these conditions as possibilities.

The most common thing, of course, statistically, would be an essential hypertension, so-called because we don't know the etiology but usually associated with sclerosis of the arterioles of the kidneys and other organs and tissues. Yet the development of a marked hypertension from a perfectly normal pressure in two years' time would seem a little bit odd, although certainly not impossible. On the basis of percentages, one must think that the hypertension probably was on the basis of essential hypertension.

If this was a dissecting aneurysm of the aorta, what evidence do we have to indicate it, other than the history of rather characteristic chest pain with radiation? We know that the aorta was sclerotic in patches, we had a severe hypertension, and we had tests which were positive for syphilis. Arteriosclerosis in the presence of either hypertension or syphilis can be etiological, weakening the aorta in places and laying the groundwork for a dissecting aneurysm to develop. This patient had a marked drop in blood pressure a few hours after his entrance into the hospital, and the blood pressure never again became even moderately high. This, of course, would be consistent

with his having sustained a myocardial infarction on entry. It would be consistent, also, with a dissecting aneurysm. In the presence of arteriosclerotic changes of the aorta, whether they are basically arteriosclerotic or related to syphilis, sometimes changes are found involving the cusps of the valves, with obstruction to the flow of blood in relation to the sinuses of Valsalva and entry into the coronary arteries. In other words, the coronary ostia may be obstructed partially by arteriosclerotic changes of the aortic valve, which produces a decreased flow of blood through the coronary vessels. On the other hand, arteriosclerotic changes of the coronary vessels may narrow their lumina. In syphilis, the coronary arteries are narrowed at times due to changes in the aorta at the ostia. With a marked decrease in blood pressure for any reason, there undoubtedly is a marked reduction in coronary blood flow so that, in a patient sustaining a marked drop in pressure due to some other reason than coronary occlusion, one would expect his coronary flow to be decreased markedly. From that time on, he would be susceptible to the development of an infarction in the heart wall.

My line of thinking leads me to believe that this was the course of events in this case; that is, a marked decrease in blood pressure produced a markedly decreased coronary flow. The patient had a diastolic murmur described as characteristic of an aortic valve regurgitation. This could be due to arteriosclerotic changes or to syphilitic changes. We have no means of deciding to which it might be due; and I doubt if a pathologist, on examination of the tissues, could tell whether aortic regurgitation in a case such as this is due primarily to arteriosclerotic changes or to syphilitic changes. But he did have an aortic regurgitation; and that predisposes to a low coronary flow because of reduced pressure in the ascending aorta during diastole, laying the groundwork for myocardial ischemia and later development of myocardial infarction. My line of thinking, then, is that this patient, when he came in, had pain, not due to coronary occlusion, but due most probably to dissecting aneurysm of the aorta. It is possible that such a dissecting aneurysm may have gradually, as it progressed, developed pressure on the coronary arteries or one coronary artery to narrow the lumen. Whether that obtained or not would be merely a guess; I don't think one can be certain. I think that the ensuing myocardial infarction, which occurred about the sixteenth to eighteenth day, could have resulted just as well from decreased coronary flow as from other reasons which have been mentioned.

Now we come to the sixteenth day, when a pericardial friction rub, characteristic of a myocardial infarction, as well as a characteristic acute posterior infarction curve on the cardiogram, developed. On the eighteenth day the blood pressure fell to 70 systolic, and sudden collapse of the patient, with an increased pulse rate, occurred following a low enema. Anticoagulant therapy was started on this day. Digitalis given at this time and later produced no benefit. I think that one wouldn't expect digitalis or anticoagulant therapy to do very much at this time. About 20 days later numbness of the thighs and legs, inability to move the lower extremities, and absent femoral pulsations developed. This could be due to a saddle embolus involving the bifurcation of the aorta. Of course, one would presume that the embolus came from a mural thrombus in the left ventricle. On the other hand, it could be due to a dissecting aneurysm. However, I think that the most likely thing in this case was originally a dissecting aneurysm of the aorta, followed by myocardial infarction based on decreased coronary flow, possibly due to arteriosclerotic or syphilitic changes in the coronary arteries or possibly due to pressure from a dissecting aneurysm on the coronary arteries. The numbness and paralysis of the lower extremities and absence of femoral pulsations which followed 20 days later probably resulted from further dissection of the aortic aneurysm. I may be wrong; they may have been due to a saddle embolus. There remains the possibility of rupture of the myocardial wall at the site of the infarction on the eighteenth day, with resultant hemopericardium. This, if massive, probably would produce death within a short time. Since the patient lived for almost three weeks longer, I believe cardiac rupture did not occur.

Dr. P. R. Sholl: What is the mechanism of pain in dissecting aneurysm?

Doctor Nuzum: It is my understanding that as dissection of the aorta occurs, it involves one branch after another and the pain is in the areas supplied by the involved vessels. In a typical case of a dissecting aneurysm, pain may start in the shoulders and progress downward, involving the intercostal mesenteric and renal vessels. If the aneurysm produces absence of femoral pulsations, one would have to assume that it involved both iliac arteries. The pathways of pain overlap in aortitis and coronary heart disease. The sensory nerve pathways from the heart are through the first six thoracic nerves. The same type of pain can be produced by xiphoidalgia as the nerve pathways from the xiphoid overlap those from the heart.

Doctor Gutmann: I favor a saddle embolus rather than further dissection of the aneurysm as the cause of obstruction of the lower aorta and iliac vessels. A further dissection would have affected the mesenteric and renal arteries, and there is no evidence of this. It seems to me much more likely that the occlusion resulted from embolization of a mural thrombus from the left ventricle.

Pathologic Findings

Dr. M. B. Llewellyn, Pathologist: The pertinent findings were confined largely to the heart and aorta. The pericardial sac contained about 500 cc. of old and very recently clotted blood. About 300 cc. of moist, dark red clot was removed easily. However, about 200 cc. of drier, reddish-tan clot was firmly adherent to the parietal and visceral pericardium due to organization taking place from those surfaces. This old clot measured up to 4 cm. in thickness over the right atrium and gradually tapered off over the right ventricle and other chambers of the heart, where it measured a few millimeters in thickness. The heart valves were normal in appearance except for moderate dilatation (10 cm.) of the aortic valve. The ascending aorta measured 10.5 cm. in circumference, indicating mild ectasia. Six cm. above the left posterior aortic cusp the aorta showed a transverse tear measuring 7.5 cm. in length. The intima of the ascending aorta was smooth and yellow except for a few small yellow plaques behind and just above the aortic cusps. Below the tear the aorta was split into two layers, which were separated by

Fig. 1—Gross specimen showing transverse tear through intima and inner media, 6 cm. above aortic valve. Note absence of syphilitic changes and only moderate atherosclerosis.

a reddish-tan blood clot 2.5 cm. in thickness. This was continuous with the clot covering the right atrium and extending onto the other chambers. The transverse segment of the arch showed irregular light yellow plaques up to 1.5 cm. in diameter located particularly about the ostia of the innominate, left common carotid and left subclavian arteries. Smaller similar plaques were seen about the ostia of the intercostal arteries, and plaques varying from a few millimeters to 1.5 cm. in diameter were scattered throughout the entire length of the aorta. The intima between the plaques in the descending thoracic and upper abdominal segments showed scattered longitudinal wrinklings. The distal 9 cm. of the abdominal aorta just above the bifurcation showed a fusiform dilatation measuring 8.5 cm. in circumference. The intima was ulcerated, and a tan thrombus was adherent to it. The thrombus extended into both iliac arteries to obstruct them completely.

The right coronary artery showed severe atherosclerosis. The lumen of the first 1 cm. was about 2 mm. in diameter. Beyond this point it was occluded almost completely by pale yellow subintimal thickening. The branches of the left coronary artery showed slight to moderate atherosclerosis, but their lumina were not narrowed appreciably. The posterior two-thirds of the interventricular septum and the adjacent one-third of the left

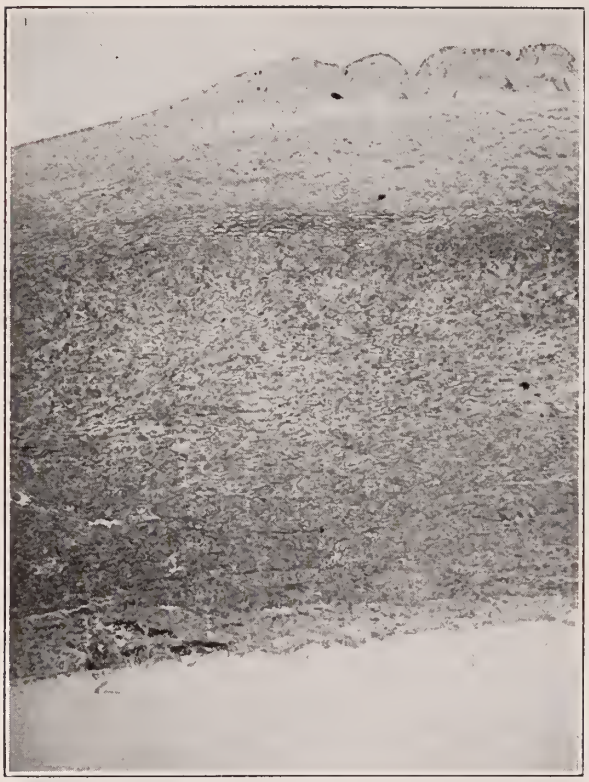

Fig. 2—Aorta showing sponginess of the media and changes in the arrangement of the elastic laminae (H & E, X 45).

Fig. 3—Aorta showing pale, loose degenerating media with irregular, broken elastic fibers (H & E, X 115).

ventricular wall were thinned; and sections showed numerous small, irregular, tan necrotic areas surrounded by greyish-brown edematous tissue. The remaining heart muscle was firm and reddish-brown. After fixation, the heart weighed 320 gm.

Microscopic examination of the heart showed an infarct of about three weeks' duration. The right coronary artery showed severe subintimal atherosclerosis with extreme narrowing of the lumen. The pericardium showed organization of the clot by granulation tissue which was dense and fibrous for a thickness of approximately 2 mm. Multiple sections of the aorta showed numerous scattered focal areas of medial necrosis involving smooth muscle, and elastic laminae with disruption of fibers and small pools of myxomatous material. The right kidney showed an acute pyelonephritis.

Diagnoses:

Dissecting aneurysm, ascending aorta
Secondary rupture into pericardial sac
Hemopericardium with organization
Recurrent hemorrhage causing cardiac tamponade
Idiopathic medial necrosis, aorta
Severe atherosclerosis, right coronary artery
Posterior myocardial infarct
Severe atherosclerosis with ulceration, lower abdominal aorta
Thrombotic obstruction, lower abdominal aorta and both common iliac arteries
Acute pyelonephritis, right kidney

Clinical Correlation

Doctor Llewellyn: Doctor Nuzum did an excellent job interpreting the clinical aspects of this case to diagnose correctly the major pathologic lesions. His approach was logical, and his conclusions covered the situation except for the intrapericardial hemorrhage, which he considered but discounted.

The sequence of events in this case can be summarized as follows: On the day of admission a dissection of the ascending aorta occurred, producing severe pain radiating into the back and neck associated with a transient rise in blood pressure and a dias-

tolic murmur which persisted for four days. On the sixteenth day, secondary rupture of the dissecting aneurysm into the pericardial sac occurred, producing the loud pericardial friction rub. Eighteen days after admission, the patient sustained a posterior myocardial infarct with signs of peripheral vascular collapse. This was due to marked atherosclerotic narrowing of the lumen of the right coronary artery. Shortly before the patient's death, a thrombus formed over extensive atheromatous ulcers of the lower abdominal aorta and common iliac arteries to occlude completely these vessels and shut off arterial circulation to the legs. Between the sixteenth day and the day of the patient's death there may have been intermittent slight bleeding into the pericardial sac; but for the most part, the bleeding point must have been sealed off temporarily, to open widely again on the last day of life, causing death by cardiac tamponade.

Discussion

Doctor Llewellyn: Doctor Nuzum in his discussion remarked that he doubted if a pathologist could distinguish between syphilitic and arteriosclerotic changes in the ascending aorta. Unless advanced atherosclerosis is superimposed on syphilitic aortitis, the distinction is usually not difficult grossly or microscopically. In syphilis the intima shows pearly thickenings with longitudinal wrinkles, without fat and calcium; the media is poorly defined; and the adventitia is thickened. Microscopically, the intima shows fibrosis and hyalinization, the media fibrous connective tissue scarring and increased vasa vasorum with perivascular lymphocytic and plasma cell infiltration, and the adventitia fibrous thickening with similar perivascular cellular infiltration. Although in atherosclerosis the initial change in the intima is hyaline fibrous plaques, plaques are usually present which are yellow and partially necrotic and which contain fatty and calcific deposits. Microscopically, the early lesions show loose fibrillar tissue and macrophages with foamy cytoplasm and the older lesions an increase in collagenous fibers, necrotic areas with cholesterol clefts, and calcium deposits. The media may be thinned, but the vasa vasorum are not increased and perivascular lymphocytic infiltration is not prominent. Intimal atherosclerosis sometimes causes aneurysms, but these tend to be cylindrical rather than sacular as is the case in syphilis. Also, in atherosclerosis the changes are usually most severe in the abdominal aorta, in contrast to the changes in syphilis, which are usually limited to the ascending arch and upper thoracic aorta.

Grossly, in dissecting aneurysm of the aorta, which usually begins in the ascending aorta, there is a defect in the media which splits the aorta into two tubes. The inner tube consists of intima and inner media and the outer tube of adventitia and outer media. In at least two-thirds of the cases there is a tear in the inner sac. Usually this tear is transverse and located in the ascending aorta as in this case. The splitting may extend proximally to the heart or distally well down into the abdominal aorta or in both directions. In nearly all cases death is due to rupture of the outer sac, most frequently into the pericardial cavity as in this case, although it may rupture into the pleural or abdominal cavities.

Microscopically, in dissecting aneurysm there is necrosis of the elastic fibers or the muscle fibers of the media or necrosis of both seen at the site of the tear and in foci throughout the extent of the aorta. Often mucoid or myxomatous material is present in cleft-like and cystic spaces. Signs of inflammatory reaction such as vascularization and cellular infiltration as seen in syphilis are absent in the media. In the adventitia there may be some lymphocytic infiltration, but this is secondary and not the primary lesion.

Although our patient in the past had a positive serology, his aorta did not show the characteristic changes of syphilis which usually involve the ascending aorta and arch and end abruptly in the upper thoracic aorta. The lower thoracic and upper abdominal aorta did show some longitudinal wrinkling, which in this case was not due to syphilis but rather to medial necrosis.

In persons over 30 years of age, some degree of atherosclerosis of the aorta or other arteries is almost always present. Severe subintimal atherosclerosis of the abdominal aorta and coronary arteries was present in this case. In the lower abdominal aorta there was ulceration, calcification, and thrombosis. This lesion, which obstructed the blood flow to the patient's legs, and the coronary sclerosis, which was the underlying anatomic lesion of the myocardial infarc-

tion, are not etiologically related to the lesion responsible for the dissecting aneurysm of the ascending aorta except coincidentally. Even the tear in the intima occurred in an area relatively uninvolved by atherosclerosis.

In 1928, Gsell and in 1930, Erdheim, working independently, described medial necrosis of the aorta which is the underlying cause of dissecting aneurysm. Prior to that time, dissecting aneurysms were believed to be syphilitic or arteriosclerotic in origin. Gore,[1] reporting 85 cases of dissecting aneurysm from the Armed Forces Institute of Pathology, describes two varieties of aortic medial lesions. The first involves primarily the elastic laminae and is associated frequently with increased basophilic myxomatous material, often in cystic spaces. This variety corresponds closely to that described by Erdheim and occurs chiefly in patients under 40. The second type is more common and involves primarily smooth muscle. This is the lesion described by Gsell and occurs chiefly in patients over 40. A combination of the two types frequently occurs and is usually observed in the intermediate age group. Our patient showed the combined type of lesion.

To the lesion responsible for the dissecting aneurysm, Erdheim gave the name medionecrosis aortae idiopathica, and that is the proper name today. The cause of medial necrosis is not known. Ischemia of the media due to narrowing of the vasa vasorum, hypertension, intimal tears due to atherosclerosis, etc., have been suggested causes; but these may be absent in many cases. Gore and Seiwert, using both clinical and pathologic criteria, found that in only 58% of 85 patients with dissecting aneurysm was there evidence of previous hypertensive cardiovascular disease. Gore[2] postulates some congenital metabolic defect or biochemical lesion which becomes manifest only after the passage of time and the operation of unknown influences to be the cause of medial necrosis.

Dissecting aneurysm occurs most frequently between the ages of 40 and 60, although it has been reported at every age. Males are affected about twice as often as females. The reported incidence of dissecting aneurysm at autopsy is an average of about 1 in 381 cases.[3] In the last 600 autopsies at Mercy Hospital there have been 6 cases of dissecting aneurysm. Five were in males, ages 44, 54, 57, 66, and 75, and one was in a female, aged 75. Death was caused by rupture of the aneurysm into the pericardial sac in three cases; into the pericardial sac and mediastinum in one case; into the pericardial sac, mediastinum, pulmonary hili, and right pleural cavity in one case; and into the left lung in one case. In this same series there were three ruptured arteriosclerotic aneurysms of the abdominal aorta which caused death by hemorrhage and one syphilitic aneurysm of the ascending aorta and arch which caused erosion of the trachea and bronchi with death due to bronchopneumonia.

Doctor Nuzum: In our case, was there a complete intramural infarction? Could it have produced the friction rub?

Doctor Llewellyn: No, the necrosis was located in the center of the interventricular septum and the left ventricular wall. It did not involve the endocardium or the pericardium. We believe that the bleeding into the pericardial sac began on the sixteenth day. If you remember, there was a very loud pericardial friction rub, and it was not until the eighteenth day that the electrocardiogram showed any evidence of an acute myocardial infarction.

Doctor Betlach: The autopsy findings clearly indicate the cause of failure of an ante-mortem radiographic diagnosis of aneurysm. I have already indicated that the usual roentgen signs of aortic aneurysm were not present in this case.

The dissecting type of aneurysm is most difficult to diagnose by roentgen methods. This patient was never fluoroscoped; and from the description of the lesion, I seriously doubt whether it would have yielded a great deal of information. The root of the aorta is most difficult to examine. Posterior displacement of the barium-filled esophagus with displacement of the aortic arch up and to the left, plus some dampening or depression of normal aortic pulsations, would be the maximum findings one could expect; and as has happened here, dissection of the aorta in retrograde fashion with hemorrhage and organization secondary to rupture into the peri-

cardium probably would have obscured the diagnosis completely.

Doctor Llewellyn: Apparently the underlying cause of dissecting aneurysm still is being confused with syphilis and arteriosclerosis in current medical literature. Syphilis and atherosclerosis rarely produce dissecting aneurysm. Idiopathic medial necrosis is the underlying cause and is a lesion distinct from syphilitic mesaortitis and intimal atherosclerosis.

In summary, the case is one of dissecting aneurysm of the ascending aorta due to idiopathic medial necrosis with secondary rupture into the pericardial sac, complicated by a posterior myocardial infarction and an obstruction of the lower abdominal aorta and both iliac arteries by a thrombus forming over atheromatous ulcers. The most unusual feature of this case is that the patient lived for more than three weeks after the original rupture of the dissecting aneurysm into the pericardial sac.

REFERENCES

1. Gore, Ira, and Seiwert, V. J.: Dissecting aneurysm of aorta; pathologic aspects; analysis of 85 fatal cases, A.M.A. Arch. Path. 53:121–141 (Feb.) 1952.
2. Gore, Ira: Pathogenesis of dissecting aneurysm of aorta, A.M.A. Arch. Path. 53:142–153 (Feb.) 1952.
3. Holland, L. F., and Bayley, R. H., cited by Gore, I: Dissecting aneurysm of aorta; pathologic aspects; analysis of 85 fatal cases, A.M.A. Arch. Path. 53:121–141 (Feb.) 1952.

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Tuesday, October 9—Green Bay ..... Bellin Hospital
Wednesday, October 10—Menominee, Michigan ..... St. Joseph's Hospital
Thursday, October 11—Wausau ..... St. Mary's Hospital

Moderator: **Robert C. Parkin, M. D.,** Madison

Faculty and Subjects to be Covered:

George S. Kilkenny, M. D., Milwaukee: *obstetrics*
Gordon Marlow, M. D., Madison: *Hemorrhoids, Fissures and Premalignant Conditions of the Bowel*
Lamont Schweiger, M. D., Milwaukee: *Cardiac Decompensation*
Martin Seifert, M. D., Chicago: *Use and Abuse of Antibiotics and Chemotherapeutic Remedies*

Tuesday, November 27—Lancaster ..... Memorial Hospital
Wednesday, November 28—Janesville ..... Mercy Hospital
Thursday, November 29—Appleton ..... St. Elizabeth Hospital

Moderator: **George E. Collentine, Jr., M. D.,** Milwaukee

Faculty and Subjects to be Covered:

M. Edward Davis, M. D., Chicago: *obstetrics*
Thomas Geppert, M. D., Madison: *Prematurity: A Common Problem in General Practice*
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Wilson Weisel, M. D., Milwaukee: *Chest Trauma*

Tuesday, January 15—Madison ..... St. Mary's Hospital
Wednesday, January 16—Oshkosh ..... Mercy Hospital
Thursday, January 17—Sheboygan ..... St. Nicholas Hospital

Moderator: **Robert C. Parkin, M. D.,** Madison

Faculty and Subjects to be Covered:

John Hirschboeck, M. D., Milwaukee: *Hematologic Problems in Children*
Howard Lee, M. D., Milwaukee: *Bronchial Asthma, and What Can We Do About It*
Ralph Reis, M. D., Chicago: *Indications and Avenue of Approach for Hysterectomy*
James Stack, M. D., Chicago: *Low Back Pain*

Highway Safety Is a Health Problem, Too

As It Looks to Your State Board of Health

THE story of life and death as told by vital statistics records for the year 1955 has now been printed. Once again the "ten killers" get top billing; and once again accidents are third on this list, led only by cancer and heart disease when all ages are included. When only ages 1 through 34 are considered, accidental deaths are "number one."

Of course, all accidents in homes, factories, and farms as well as on the highways are included in the 2,012 total accident toll. Of this number 911,* or about 45% of Wisconsin resident accident deaths, were due to motor vehicles. The problem of these deaths and the vastly greater number of injuries is being attacked in a number of different ways, such as training in driving skill, engineering, law enforcement, and others. From the health viewpoint there are a number of considerations that should receive more attention, not only in applying what we now know to individuals but also in studying what part health conditions really do play in safe or unsafe driving. It is in this area that public health may have its principal role.

Let's look first at the aspects of individual health that have a direct bearing on how the person drives. Vision certainly is the first consideration. How well he can hear is another. Both limited vision and hearing, if noted as they should be, call for restricted licenses and special care on the driver's part. Where the defect is concealed, there's danger to the individual and to others as long as he is behind the wheel.

Certain physical conditions suggest caution. The law permits an epileptic to drive provided he is under medical care and has not experienced a seizure for two years or more. Individuals who have diabetes and have "blacked out" while driving are required to be under a physician's care. Those with heart disease may at least need to restrict their driving to avoid becoming overtired. Persons with other physical handicaps such as the loss of a hand or leg also need a careful medical evaluation as well as special mechanical equipment on the cars they drive.

Other conditions are not so obvious. How fast can a person react in an emergency? Those who have been driving for years seldom question their own ability. Yet while years alone do not give a final answer, chances are that the older person does react more slowly than he used to and needs to drive with greater caution. Mental ability may affect reaction time in an emergency. The use of alcohol temporarily changes the physical ability of a driver to meet driving demands. Illness or simple fatigue reduces alertness. Then there are temporary upsets such as a family squabble or perhaps an impending visit to the dentist that may distract a driver's attention.

It is very difficult to say just how much mental health or emotional stability affects our ability to drive safely. How can we measure these factors? Certainly emotionally upset or unstable persons can be hazards at any age either because they are thinking of other things than driving or do not have a proper attitude toward others on the highway. But when should they be forbidden to drive?

Just what physical and emotional characteristics do drivers of "death cars" have? What factors that control human behavior let them act in a way to cause an accident? Can such things as lack of respect for others, immaturity, lack of good judgment that leads to a fatal accident, be foreseen or, more important, be overcome?

Today we do not have answers to questions like these, but some studies have been begun especially by industries that employ many drivers and by agencies interested in highway safety. The recent action of the State Medical Society of Wisconsin in establishing a Division on Safe Transportation is another forward step. Other studies like the Cornell University automobile crash injury research project, now extended to Minnesota, consider not only what happens to the driver but also to his passengers as the accident happens. Recommendations for the use of seat belts have already come from these

*This lists only Wisconsin residents and includes those who died on highways in other states. On Wisconsin highways 932 persons, many from out of the state, lost their lives in 1955.

investigations and are being further stimulated by official action of the State Medical Society.

Perhaps another line of attack on the multiple problems of highway safety could be made by applying the epidemiological techniques that have been so successful in solving problems in the control of communicable diseases.

Only a beginning has been made. Many more studies are needed. Looked at from the viewpoint of health, the highway accident today is a leading public health problem, causing illness and death to large numbers of people. It's a personal health problem, too, for driver, passenger, and sometimes the innocent bystander. Anything that can be done to prevent or lessen the effects of these accidents is another step toward safer, healthier living.—LUIDA E. SANDERS, *Director, Division of Health Education.*

INTERNATIONAL CANCER CYTOLOGY CONGRESS

The first International Cancer Cytology Congress, sponsored jointly by the International Union Against Cancer, the College of American Pathologists, the American Society of Clinical Pathologists, and the Inter-Society Cytology Council, will be held at the Drake Hotel, Chicago, on October 9, 10, and 11, 1956.

SCIENTIFIC PROGRAM

TUESDAY, OCTOBER 9

Chairman: Charles S. Cameron, New York — MORNING

The Historical Landmark in Exfoliative Cytology	George N. Papanicolaou, New York
The Present-Day Scope of Clinical Cytology	John B. Hazard, Cleveland
Structure of the Fixed and Stained Cell	Isadore Gersh, Chicago
Possibly Distinctive Properties of Malignant Cells	E. V. Cowdry, St. Louis
Normal Cells Originating in Respiratory Tract	Eileen King, San Francisco
Pulmonary Cancers and Their Cells: A Study of Sputum	John B. McDonald and Lewis B. Woolner, Rochester, Minn.
Pulmonary Cancers and Their Cells: A Study of Bronchial Washings	Nathan Chandler Foot, New York

Chairman: David A. Wood, San Francisco — AFTERNOON

The Cellular Content of Effusions Not Related to Cancer	Sarah Luse, St. Louis
Recognition of Malignant Tumor Cells in Effusions	Otto Saphir, Chicago
The Cellular Detection of Carcinoma of the Esophagus	F. Thomas Gephart, Boston
Normal and Abnormal Cells in Gastric Washings	John Seybolt, New York
The Cellular Detection of Cancers Involving Urinary Tract	Walter T. Wikle, Denver
A Pathologist's Views on the Subject of Cytology	David C. Dahlin, Rochester, Minn.

Panel Discussion: Aspiration Biopsy

WEDNESDAY, OCTOBER 10

Chairman: Lewis C. Scheffey, Philadelphia — MORNING

Problems in Mass Screening	Cyrus C. Erickson, Memphis
The Automatic Scanner	Walter E. Tolles, Mineola, N. Y.
Normal Cells Arising in the Female Genital Tract	Charlotte M. Street, New York
Metaplasia of the Uterine Cervix	Hugh F. McCorkle, Cleveland
Atypia of the Uterine Cervix and Its Relation to Trichomoniasis	T. R. Simon, L. G. Koss, and Wanda Wolinska, New York
"Pre-Cancerous" Changes in the Uterine Cervix	Edward E. Siegler, Cleveland

Panel Discussion: Problems in Confirming Cellular Evidence of Cancer

Chairman: Osborne A. Brines, Detroit — AFTERNOON

Cellular Changes Simulating Those of Cancer	Ruth M. Graham, Boston
Cellular Study of Epithelial Dysplasia in Pregnancy	William D. Walters, Detroit
Squamous Cell Cancer of the Uterine Cervix: A Histo-Cytological Study	J. L. McCormack, Cleveland
The Cellular Detection of Uterine Adenocarcinoma	John Berg and Grace R. Durfee, New York

Panel Discussion: Prognosis in Cancer of the Uterine Cervix as Determined by Histologic and Cytologic Methods

THURSDAY, OCTOBER 11

Chairman: Emerson Day, New York — MORNING

New Advances in Cytology (papers to be selected)

Chairman: James B. McNought, Denver — AFTERNOON

Symposium: Carcinoma in Situ of the Uterine Cervix

For specific information concerning the Congress, write Dr. Arthur H. Dearing, College of American Pathologists, Prudential Plaza, Suite 2115, Chicago 1, Illinois.

. . . . THE PRESIDENT'S PAGE . . . .

Sowing Seeds of Satisfaction

IN MY address to the House of Delegates, I mentioned the numerous committee meetings held by the State Medical Society and their invaluable contributions to medicine and the public good. Just to give you an idea, here are a few of the meetings held recently:

1. **Commission on Prepaid Plans.** Unlike the directors of most business ventures, this commission is not interested in making money. It is interested in giving the public *more* benefits and in exploring means of helping people take care of the expenses of long-standing illness. It is interested in paying claims rather than disallowing claims. It is thinking of increasingly better medical and hospital coverage at reasonable cost. It is experimenting with paying the physician's regular fee in his own community rather than fees which have state-wide application. Under this program, any differences of opinion concerning fees are settled by county medical societies instead of at the state level.

2. **Council on Scientific Work.** Here is a council composed of the deans of the two medical schools, the editor of the Medical Journal, and five physicians representing general practice and the specialties. They are charged with the development of the Annual Meeting program and other teaching activities throughout the year. Their evaluation of the May, 1956, program will result in elimination of what they think has been of little interest and in keeping that which has been valuable. They are not only interested in their own specialties but have a marvelous insight into the needs of the general practitioner and physicians as a group. I hope that you will write the Society and indicate the kind of program you prefer.

3. **Committee on Public Policy.** This committee met with the State Board of Medical Examiners. It is interested in protecting the public from many of the so-called "quacks" who prey upon the public. At the same time, it is interested in promoting legislation which will result in better public understanding of the limitations of "limited licensees" and in improving public health care. This committee and the Board of Examiners are, of course, made up of the finest type practitioners of medicine; and they believe that frank discussions of mutual problems will produce real accomplishment.

4. **Committee on Hospital Relations and Council on Medical Service.** You can imagine the many questions that this committee and council could discuss. What hospital facilities are there in Wisconsin? Should small hospitals be accredited; and, if so, should they have less strict standards? Should hospital administrators select the chief of staff, or should the medical staff select its chief? Does the hospital board meet with the medical staff at intervals? How should county societies help in resolving differences of opinion between medical staffs and hospital administration?

I tell you these things because the active membership often has little knowledge of what goes on in committee meetings, despite numerous notices in *The Wisconsin Medical Journal.* Doctors seem too busy to read all that is in the Journal. But I do want you to know that the more than 300 physicians on about 35 committees are working hard, primarily to do what is best for the public interest. Only with this motive of public service can physicians retain the high respect they presently enjoy. If every physician will sow the seeds of honesty, sincerity, helpfulness, and leadership in his own locality, he will have served his patients and his community well; and he will most certainly enjoy the feeling of satisfaction that comes only with personal contribution.

L. O. Simenstad M.D.

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Surprising Results from Annual Meeting Survey

The unusual response and the many fine comments and helpful suggestions received in connection with the questionnaire concerning the Annual Meeting, sent to all members of the State Medical Society of Wisconsin earlier this year, will enable the Council on Scientific Work to produce an Annual Meeting program better designed to meet the desires of Wisconsin physicians.

However, it was apparent from the comments that what pleases one physician displeases another. A quick run through the 1,200 returned questionnaires reveals the following remarks as an example:

Use more outside speakers—Use more in-state speakers
Material too basic—Get down to fundamentals
Have more specialty lectures—Put on more for the generalist.

With the wide variety of practice and specialty interests represented by more than 3,200 physicians, it is almost impossible to produce a program to please everyone. However, the Council on Scientific Work would like to comment on a few of the results of the questionnaire survey. Many of the problems concerning the Annual Meeting deserve clarification.

Attendance. There are 3,249 members of the State Medical Society residing in Wisconsin. A total of 1,632 of them attended the Annual Meeting in May. It is interesting to note that 746 of these physicians reside in Milwaukee County, and 146 were from Dane County. Thirty or more members attended from each of the following county medical societies: Brown–Kewaunee–Door, Fond du Lac, Kenosha, Racine, Rock, Sheboygan, Waukesha, and Winnebago. Fifty-three specialties or subspecialties were represented by the physicians in attendance. Of course, the greatest number were in general practice; but 205 indicated surgery and 154 internal medicine as a full or part-time specialty.

Television. A substantial percentage of the replies indicated a preference for television in the 1957 Annual Meeting program. The Council on Scientific Work will develop such a program with Smith, Kline & French Laboratories, utilizing "live refresher courses" direct from Milwaukee hospitals.

Refresher Courses. One common statement concerning the 1956 refresher courses was that there should not be limitations on attendance. While there was general agreement that there should be more

refresher-type courses, either for small groups or as general sessions, the Council has a real problem trying to provide adequate meeting space in the Milwaukee Auditorium facilities. The obvious desire of most physicians to "let down the bars" on attendance at refresher courses indicates a need for more serious consideration to this type of presentation. Some means must be devised, however, to adequately plan for seating arrangements and an audience for the speaker for each refresher course.

General Practice Day. This was by and large a well-accepted innovation and prompted a great many comments suggesting wider variety of subject material and a desire for more color and action in presentations.

Specialty Meetings. The wider variety of specialty meetings held in 1956 proved extremely popular, although specialists were prone to characterize these sessions as "not specialized enough." However, the Council on Scientific Work is encouraged by the fine response to the specialty meetings and the excellent cooperation of the specialty sections and societies in presenting material of interest to general practitioners as well as to members of a particular specialty. This type of program will be expanded in 1957 in an attempt to come somewhat closer to the philosophy of "something for everyone."

General Comments. One physician suggested that a "no smoking" rule be invoked during lecture sessions; another suggested permitting members to enter the speaking hall only between addresses; another asked for the elimination of the scientific meeting entirely and devotion of the Annual Meeting only to organizational matters; others suggested more round tables, more specialty sections, more refresher courses, more television, more films, more practical material, more outside speakers, more variety in program material, more panel programs, more wet clinics, and more on civil defense—and not to be overlooked was the suggestion for more adequate parking facilities.

The Council on Scientific Work is pleased that its 1956 presentation was overwhelmingly popular. However, the suggestions of the members as elicited by the questionnaires will be of invaluable assistance in planning future programs.

All criticisms, plaudits, comments, and suggestions have been reviewed by the Council on Scientific Work, the general Council, and the staff of the State Medical Society. They were deeply appreciative of the time and effort spent by the physicians who returned the questionnaires. Comments and queries from any member of the Society are welcome at any time and will be given careful consideration.

Let's Focus Attention on Needs of the Aging

The recent Governor's Conference on an Aging Population emphasized interesting highlights on the problem of aging. Members of the Division on Geriatrics of the Commission on State Departments of the State Medical Society and several other physicians actively participated in the workshop discussions, which covered a wide range of the problems related to aging.

In discussing the scope of the problem, Dr. Frederic Swartz emphasized that "environment and our reactions to it determine how long we live and how well we adapt ourselves to old age. Environment is something that man alone can do something about." The stigmata of senescence caused by environmental stress we can do something about, but we cannot change time. The changing silhouette of medicine needs new concepts to provide the proper motivation for the old to keep hope. Doctor Swartz pointed out that lack of preparation for the increased years is the real cause of deterioration, and the resulting change of old age is the impact from the environment.

The physicians of Wisconsin, through their county medical societies, should first focus attention on the relatively small percentage of elderly persons with immediate serious health problems to determine the physical facilities required for their adequate care. To properly assume the role of leadership, the physicians must be adequately informed of the problem of aging in all its ramifications.

The county medical society should develop a unanimity of action and opinion and should develop a better working relationship with the State Health Department, the nursing associations, the welfare groups, and all allied organizations. There is need for an interprofessional team approach of health and related services. The county medical society is urged to organize joint planning for the aging with representation of all organizations concerned. Repeated meetings with those organizations augur well for cooperation of all.

We, as physicians, should take an active part in the study of the total individual and properly concern ourselves with community planning, community resources, home care, the effective use of institutions, the role of the church, the employment of older individuals, leisure time, and the education of older persons.

The county medical society is urged to initiate and participate in broad educational efforts to inform the public on health and medical needs of an aging population and to encourage support of sound programs to meet those needs.—ADOLPH M. HUTTER, M. D.

Press Reaction to Social Security Expansion

But Where Will It End? . . .*

No one would quarrel with the humanitarian aims of the Social Security legislation recently passed by the Senate which would lower the retirement age for women and permit totally disabled persons to receive benefits starting at age 50.

And certainly no one could reasonably complain that a Social Security tax increase of half a per cent, split between employer and employe, would in itself be burdensome.

Nevertheless, and in the face of unanimous Senate approval of the measure, there is ground for doubt about the legislation.

There is more than a little doubt, for instance, concerning the desirability on sociological grounds of encouraging the retirement of women at 62. And there is considerable questioning about the practicality of the disability provision because of possible serious complications in trying to administer it.

Of possibly even greater concern, however, is the question it seems to raise of where will it stop. The program has been steadily broadened, the last liberalization being just two years ago. And in the main, expansion and liberalization call for higher Social Security taxes. Each increase in itself may be small, but certainly over the years it can add up considerably. Tax increases brought about by expansion and liberalization coupled with the Social Security tax increases scheduled under past provisions of the program could conceivably add up to a tax burden of a size to threaten the entire program.

It is the implications of the tendency toward continual expansion and liberalization of the program rather than any single move in that direction which seem to create the greatest grounds for questioning.

Expansion of Social Security in This Election Year Had Its Political Angle**

It is not to be doubted that humanitarian motive and purpose had part in what Congress did regarding the Federal Social Security program. But a substantial element in the law-making body quite certainly had political thoughts that swayed them more than anything else.

And it does not need much figuring to show that the two changes made will cost a lot of money and keep on being a high-priced proposition as time runs on.

Of course, the lowering of the retirement age for women from 65 to 62 will help many older women who find it hard to get jobs at their age. There were no votes in the Senate against this alteration in the law.

Granting payments to the disabled at the age of 50 encountered opposition. Social Security was established to give benefits to the aged, not to take care of those who suffered misfortune before they reached retirement age.

Help for them is needed, but it is open to question whether it should be given under a system set up for a different purpose.

It is estimated the changes in the law will cost 200 million dollars the first year. And Senator Byrd, who opposed the change, estimated it might eventually cost more than $800,000,000 annually in the extra bill presented to those covered by Social Security.

The money additionally required will have to be raised in added taxes on employers and employes. How great the boost will be has yet to be determined by a conference between the Senate and the House.

Politics played a hand in putting the changes across. The Democrats were fully aware of the popular appeal of the proposals and are prepared to make an election issue of them if the President exercises his veto.

Friends of Social Security who want the system to remain healthy and continue indefinitely may well give thought to the implications of this expansion. There are limits to what the program can stand and survive. Future expansions could be disastrous to the purpose for which the system was established.

The Heck With the Piper***

In all the tinkering and liberalizing that has been done to the Social Security law since its adoption in 1935, the benefit age of 65 for retired workers has remained unchanged. The 1954 changes, quite extensive both in benefits and coverage, did not lower the age for qualifying.

The House, however, dropped the age for women to 62 years in its 1955 session. The Senate now has done the same, with variations. Since the Senate vote was unanimous on passage Tuesday, there is no doubt that a thoroughly liberal and expensive compromise will be approved before Congress adjourns.

The House version would cost an estimated $400 million a year to start with—and much more in the future—for the single feature of lowered age for women. The Senate split the difference on that by providing full benefits only for widows at the lower age; wives and working women would take benefit cuts in exchange for becoming eligible three years sooner.

Both House and Senate would spend another $200 million or more a year by allowing benefits to disabled workers at age 50. Their bills call for a separate pay roll tax of one-fourth per cent each on

*Reprinted from the July 20, 1956, *Wausau Daily Record-Herald*.

**Reprinted from the July 23, 1956, *Oshkosh Daily Northwestern*.

***Reprinted from the July 19, 1956, *Wisconsin State Journal*, Madison.

employer and worker to cover the disability provision.

* * *

Neither the Eisenhower Administration nor the Social Security people oppose better coverage and more liberal payments. But they have well-founded fears about adopting them now.

The system is "liberalizing" too fast and going too far. This year some 70 million workers and their bosses are kicking in $6.7 billion in payroll tax; some eight million persons will receive $6 billion in benefits. The tax now, divided equally between employer and employe, is 4 per cent on the first $4,200 earned. In 1960 it goes to 5 per cent, and will go up each five years thereafter to reach a top of 8 per cent in 1975.

That is a whopping big bite out of anyone's pay check: What is worse, the outgo almost certainly will exceed income from the pay roll tax at some future time in spite of the higher rates.

The rest will have to come out of the general tax pot. A drop in employment, of course, would mean more benefit checks and less fund income.

* * *

The Senate vote this week showed the real danger to the system: the temptation to buy votes without regard for the future. Why should the retirement age for women be lowered at a time when they are living—and staying on the job—longer, except to win votes? Does anyone suppose there won't be pressure next year to lower the age for men?

The Congress is doing the oldsters—and their children—a disservice with this kind of shenanigans. Apparently they don't believe that pipers have to be paid, or don't care.

President Eisenhower, election year or no, should veto the bill to protest the soundness of the system.

WISCONSIN RADIOLOGICAL SOCIETY MEETING

The annual meeting of The Wisconsin Radiological Society will be held at Northernaire, Three Lakes, Wisconsin, on Friday, Saturday and Sunday, October 12, 13, and 14, 1956.

The scientific program will be presented by members of the society, and the guest speaker will be Dr. Harold O. Peterson, Professor of Radiology, University of Minnesota Medical School. Doctor Peterson will speak on the subject of "Myelography."

The medical profession is cordially invited to attend the scientific program.

POSTGRADUATE COURSES ON DISEASES OF THE CHEST

The Council on Postgradute Medical Education of the American College of Chest Physicians will sponsor the following postgraduate courses on diseases of the chest this fall:

11th Annual Postgraduate Course, Chicago, Illinois, Hotel Knickerbocker, October 15–19

9th Annual Postgraduate Course, New York City, Park–Sheraton Hotel, November 12–16

Tuition for each course is $75, which will include daily round-table luncheons. The most recent advances in the diagnosis and treatment of chest diseases will be covered.

Further information may be obtained by writing: Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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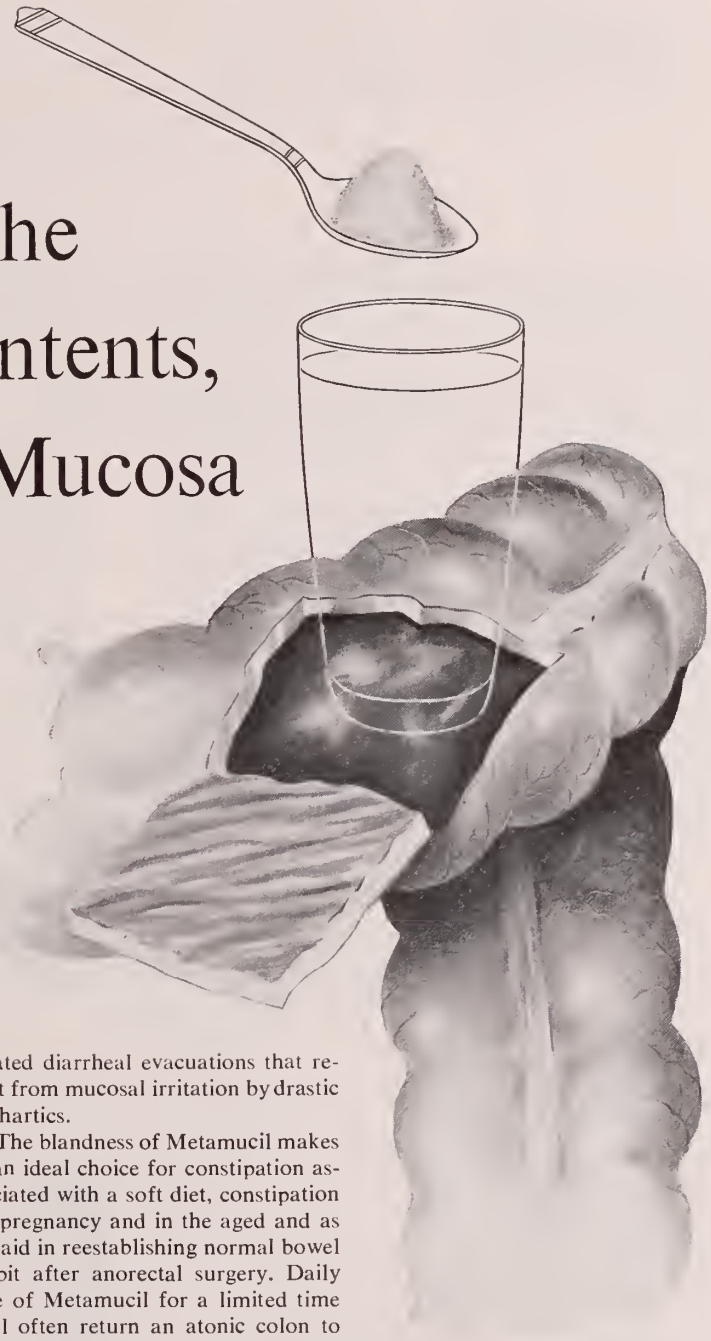

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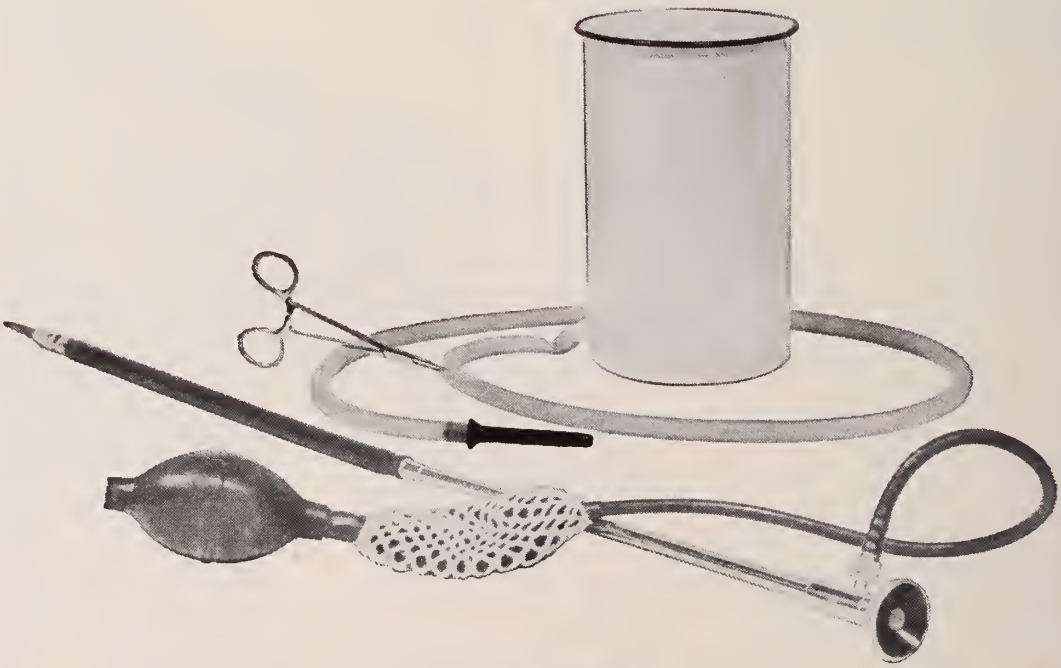

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. . . gleanings from the Section on Medical History

It's no secret that the number one project of the State Medical Society, historically speaking, is the restoration of the Beaumont Hospital at Prairie du Chien. The project is to be undertaken by the Section on Medical History and the Society's Charitable, Educational, and Scientific Foundation Incorporated, in cooperation with the Wisconsin State Historical Society.

It is hoped that the restoration will include facilities for development of a statewide medical museum. To do this, it was estimated, $100,000 will be needed to restore the military hospital in which Dr. William Beaumont conducted a portion of his important physiological experiments on human digestive processes.

Initial steps on this plan have been undertaken, including efforts to acquire legal title to the Beaumont property and more land for parking and other purposes, and to secure aid in financing the cost of restoration.

Officers and members of the Foundation are enthusiastic about the far-reaching benefits possible when the project is completed.

* * *

A. E. Towne, Madison, of the State Department of Vocational and Adult Education, recently contributed a diploma and a set of surgical instruments which were used by his great-grandfather, Dr. L. E. Towne, who came to Wisconsin from Vermont between 1840 and 1850. He practiced in Darlington and Brodhead. The diploma shows he was graduated from Rush Medical College, February 5, 1868. Doctor Towne died in 1903.

Mr. Towne serves as a consultant to the State Medical Society's Division on Rehabilitation.

* * *

An eye catcher in the S.M.S. Council Room is a show globe, a gift from Dr. R. G. Arveson of Frederic, a past president of the Society. The globe, hand cut by English craftsmen, is more than 100 years old. It adorned a display window of a pharmacy on Milwaukee's south side for many years.

DR. ROGER E. GARRISON, State Medical Society Councilor from Wisconsin Rapids, is shown admiring the surgical instrument set once used by Dr. Lucius Eliott Towne, who practiced in Brodhead in years gone by. Doctor Towne died in 1903. The set was donated to the Section on Medical History by Mr. Adrian E. Towne, Madison, the physician's great-grandson.

The globe resembles strikingly the well-known Kipp generator, an apparatus introduced into small-scale chemical processing during the last half century. Representing two containers in one, it offers an opportunity to display two colors, and is a remarkable product of artistic glass manufacture.

* * *

Another welcome gift came from Dr. Carl D. Neidhold of Appleton. It is a bloodletter, brought to this country almost 100 years ago by his grandfather and treasured as a sort of family heirloom.

Bloodletting was practiced in the stone age as a method of treatment by scarification of the skin with sharp, pointed flints. Venesection was a form of treatment in an-

cient Greece. Hippocrates practiced venesection in 400 B.C., Aretaeus in Rome in the first century A.D.

Fighting this "bloody Moloch," Johann Gottlieb Wolstein wrote in 1791:

"In this era of intensive bloodletting, when physicians shed ceaseless streams of blood in every fever, the fever by itself is not a disease, but nature's best weapon for the combat of disease. Blood is no water—it is the juice of life; a juice which after each venesection nature replaces rapidly, but in a raw, unprepared, watery, spiritless state."

The furious bloodletters of the day did not listen to Wolstein, but kept on bleeding their patients white. It was a variety of therapeutic vampirism which sent unnumbered thousands to premature graves.

* * *

The Charitable, Educational, and Scientific Foundation Incorporated of the Society reported contributions of $6,445.50 during the period from July 1, 1955, to April 15, 1956. The contributions were made by 549 Society members and 5 other interested persons.

This summer the Foundation is making its annual request for voluntary contributions of $10—or more if you wish—from each active Society member. Donors have the opportunity to earmark for specific projects, but flexibility is extremely important in using cash or other gifts contributed to the Foundation.

* * *

In the near future, the Society, the State Conservation Department, the State Historical Society, and the State Highway Department will get together to study suitable markings for buildings, locations, and other points of interest in the medical history of Wisconsin and to develop or arrange tours which will permit study and observation.

It is hoped that such a program will create a fuller appreciation on the part of the general public of the significant role which medical men and medical science have played in the life and progress of the state.

* * *

Officers of the Foundation were authorized to negotiate for and accept gifts on behalf of the Foundation in forms other than cash, such as real estate, securities, works of art, and other items having intrinsic value. Its Executive Committee was authorized to operate low-income property, liquidate any property received by the Foundation, and make loans or gifts of items of historical or other value which the Foundation may acquire in its operation.

* * *

Do YOU have any heirlooms, any items about your home or office related to medicine which have historical connotation? The Society, its Foundation and Section on Medical History will be happy to accept and treasure such materials as medical instruments of days gone by, ledgers, or any related matter. Perhaps in time the gift you send will find its way into the Medical Museum at Prairie du Chien and be preserved for generations of the future to see and appreciate.

OTOLARYNGOLOGY MEETING

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from October 1 through 7, 1956. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose, and throat.

Interested physicians should write to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

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* * * *

The Doctor Has a Voice in Blue Shield

"The policy-making body of Blue Shield is controlled by licensed doctors of medicine. That is as it should be. If the doctors are to sponsor a pre-payment medical care enterprise, they should have a majority voice in the determination of their fees for services and other matters of major policy.

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"Through this representative method of selecting the governing body [board] of Blue Shield, the individual practitioner wishing to inaugurate some policy change may bring the matter to the attention of the doctor representative from his councilor district . . . or may voice his suggestions for improvement of the plan to the president [chairman] of the Blue Shield Board. The matter will be brought to the attention of the Blue Shield Board for thorough study, and a report of the action taken will be referred back to the individual doctor who offered the suggestion. This democratic method is utilized in the operation of all sizable corporations and is also the usual process of government. It is the democratic approach."—From April, 1956, issue, *The Journal of the Iowa State Medical Society.*

For Information or Advice
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Society Proceedings

Grant

The July meeting of the Grant County Medical Society was held July 18 at the Lancaster Country Club. The group entertained doctors of the councilor district, which includes Grant, Iowa, Crawford, Richland, and Lafayette counties.

Guests included *Drs. L. O. Simenstad*, Osceola; *H. E. Kasten*, Beloit; *J. C. Griffith*, Milwaukee; and seven Dubuque physicians. Mr. Charles Crownhart, Madison, secretary of the State Medical Society, together with 12 members of his staff, was also present.

During the business session, *Dr. Charles Shields* of Fennimore was elected president of the county society, and *Dr. K. L. Bauman*, Lancaster, was elected vice-president.

A variety of subjects relating to the practice of modern medicine were discussed by the guests.

Manitowoc

Twenty-three members of the Manitowoc County Medical Society met on May 31 at the Hotel Manitowoc in Manitowoc.

Election of officers was held, and the following now preside:

President—*Dr. H. J. Belson*, Manitowoc
Vice-president—*Dr. D. A. Kuljis*, Two Rivers
Secretary—*Dr. R. J. Banker*, Manitowoc.

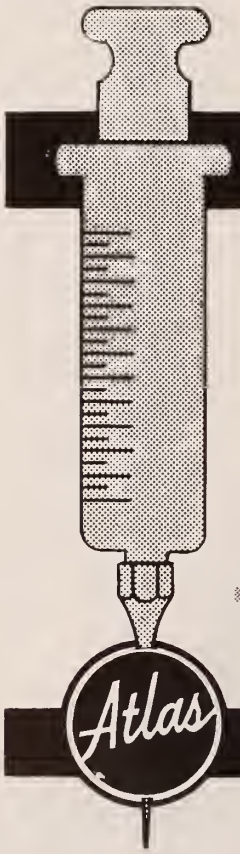
Richland

On July 19, ten members of the Richland County Medical Society met at the Richland Hospital library, Richland Center.

Guest speaker at the meeting was *Dr. H. H. Shapiro* of the Cardiology Department of the University of Wisconsin, who discussed "Coronary Artery Disease."

Wisconsin Society of Public Health Physicians

Dr. C. K. Kincaid, Madison, was recently elected president of the Wisconsin Society of Public Health Physicians. He was also named delegate to the State Medical Society. *Dr. Elmer Bertolaet*, Kenosha, was elected to serve as alternate delegate.



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News Items and Personals

Doctor Christianson Locates in Denver

Dr. Herbert B. Christianson, who has been a Fellow in the Department of Dermatology at the Mayo Clinic for the past three years, recently announced that he has located in Denver, Colorado. He is associated with Dr. E. J. Clinger in the practice of dermatology and syphilology.

Dr. Ekblad President of Railroad Surgeons Group

Dr. V. E. Ekblad, Superior, was elected president of the Soo Line Surgeons Association at a recent meeting held at Banff Springs Hotel, Canada.

Two years ago, Doctor Ekblad served as president of the Great Northern's Surgeons Association. He is local surgeon for the Soo Line and Northern Pacific railways and division surgeon for the Great Northern.

Doctor Ekblad is a member of the American College of Surgeons.

Drs. Nammacher and James Move to New Office

The offices of *Drs. T. H. Nammacher* and *W. D. James*, Oconomowoc, have been moved to a new building at 304 Summit Avenue. The doctors moved into their new offices the first week of August.

The new structure houses two offices, eight examination rooms, a laboratory, and a waiting room.

Doctor Simons Retires

Dr. N. S. Simons, Whitehall, who had been practicing medicine for 42 years, has recently retired. He was the eye, ear, nose, and throat specialist at the MacCornack Clinic.

Doctor Simons is a native of Trempealeau County. He graduated in 1914 from the University of Illinois Medical School and, prior to practicing in Whitehall, was in general practice at Taylor.

He will be succeeded by *Dr. Joseph Tschetter*, who has been associated with him since June, 1955.

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Surgical Anatomy & Clinical Surgery, Two Weeks, October 1
Surgery of Colon & Rectum, One Week, October 15
General Surgery, One Week, October 22
Thoracic Surgery, One Week, October 1
Esophageal Surgery, One Week, September 24
Breast & Thyroid Surgery, One Week, October 22
Gallbladder Surgery, 3 days, October 29
Fractures & Traumatic Surgery, Two Weeks, October 15

GYNECOLOGY & OBSTETRICS—Obstetrics & Gynecology, Three Weeks, October 22
Vaginal Approach to Pelvic Surgery, One Week, October 15

MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, October 8; One-Week Advanced Course, September 17
Internal Medicine, Two Weeks, September 24
Gastroenterology, Two Weeks, October 22
Dermatology, Two Weeks, October 15
Cardiology (Pediatric), Two Weeks, November 5

RADIOLOGY—Diagnostic X-Ray, Two Weeks, November 26
Clinical Uses of Radioisotopes, Two Weeks, October 8

UROLOGY—Two-Week Course, October 8
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*Moyer, J. H., and others:
J. Chronic Dis. 2:670, 1955.

03056

Doctor Moses Relocates

Announcement was recently made by *Dr. Robert Moses,* Delavan ophthalmologist, that he will soon move to St. Louis. He will become a full-time research worker at Washington University there.

Doctor Brook Locates in Sturgeon Bay

Dr. J. J. Brook, Jr., began private practice on August 1 in Sturgeon Bay, following a year of surgical training at Milwaukee County Hospital.

He is a 1950 graduate of Northwestern University and served his internship at Milwaukee County General Hospital. In 1952 and 1953 he practiced in Marshfield, after which he served in the army. While in the army, he specialized in obstetrics.

Dr. Theisen Joins Green Bay Clinic

Dr. J. K. Theisen, who for the past two years was chief of surgery for the anti-aircraft training center at Fort Stewart, Georgia, has joined the Goelz Clinic, Green Bay. He will limit his practice to surgery.

He is a graduate of the University of Wisconsin Medical School. After serving his internship at St. Luke's Hospital in Cleveland, he was called into military service and assigned to the staff at Wood. In 1953 he was a member of the staff of the Marshfield Clinic, Marshfield.

Sturgeon Bay Doctors Form New Clinic

Drs. H. D. Grota and *H. R. Peters* have announced their association in what will be called the Sturgeon Bay Clinic.

The association will make possible more complete service and efficient handling of emergency calls, and also will make available x-ray, laboratory, and physiotherapy facilities.

Rice Lake Physician Heads Area Medical Group

Dr. W. F. Vaudreuil has been elected president of the newly formed Indianhead Chapter of the Wisconsin Chapter of the American Academy of General Practice. This chapter will cover the area from Superior to Chippewa Falls and from St. Croix Falls to Park Falls.

Doctor Vaudreuil was elected at the organization meeting of the new group held July 25 at the Elks Club in Rice Lake. The charter presentation was made by *Dr. R. R. Richards,* Eau Claire, state chapter president. Forty area physicians joined the group. *Dr. J. R. Guy,* Barron, was named secretary-treasurer.

Dr. Hadley Enters Residency Training

Dr. J. O. Hadley, Watertown, recently announced that he is entering residency training at the Mil-

waukee County Hospital for the next three years. He has been located in Watertown in general practice for four years.

His practice is being taken over by *Dr. E. P. Schuh,* who was formerly in general practice in Tigerton.

He is a graduate of Northwestern University Medical School and served his internship at Milwaukee County Hospital.

THIRD AND TWELFTH DISTRICTS NEWS

Three Wisconsin M.D.'s Become Fellows of Chest Physicians Group

At the 22nd annual meeting of the American College of Chest Physicians held in Chicago on June 6 to 10, *Drs. H. B. Benjamin,* Milwaukee; David Krongold, Wood; and *J. R. Talbot,* Madison, received their certificates of fellowship in the College.

Dr. A. A. Busse of Jefferson serves as Governor of the College for Wisconsin.

Dr. Daley Moves to Whitehall

Dr. George M. Daley has recently located in Whitehall, where he will be associated in the practice of surgery with *Dr. R. L. MacCornack, Sr.*

Doctor Daley is a 1952 graduate of Marquette University School of Medicine. He interned and completed his residency in general surgery at St. Joseph's Hospital, Milwaukee.

Dr. Welsh Elected Arthritis Group Official

Dr. Edwin C. Welsh, Milwaukee, was elected a member of the board of directors of the Wisconsin chapter of the Arthritis and Rheumatism Foundation at the annual meeting on July 9. The meeting was held at the University Club in Milwaukee.

Dr. Peterman Chairman of A.M.A. Section

Dr. M. G. Peterman, Milwaukee pediatrician, was recently elected chairman of the Section on Pediatrics of the American Medical Association.

Doctor Peterman is a member of the Division on Crippled Children of the state society's Commission on State Departments. He has given many addresses throughout the country on handicapped children and on the convulsive diseases of childhood.

Dr. Zell Accepts County Position

Dr. John Zell was recently named psychiatrist of the Jefferson County Welfare Board. His new duties began on August 1.

He will conduct his guidance work on a part-time basis, leaving the full-time post with the Milwaukee County Guidance Clinic which he has held for a year and establishing a private practice in Milwaukee. He will be at the courthouse clinic four days a month.

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Beatrice A. Berteau, 1742 South 52nd Street, Milwaukee.

L. W. Worman, 8700 West Wisconsin Avenue, Milwaukee.

G. B. Theil, Milwaukee County Hospital, Milwaukee.

M. K. Rosenbaum, 3567 East Barnard, Cudahy.

A. H. Pemberton, 6055 North Bay Ridge Avenue, Milwaukee.

P. E. Doermann, Milwaukee County General Hospital, Milwaukee.

C. F. Blunck, 1300 University Avenue, Madison.

F. E. Ehrlich, 1932 University Avenue, Madison.

F. B. Hege, 424 North Patterson Street, Madison.

D. C. Lane, 1300 University Avenue, Madison.

W. B. Parsons, Jr., 30 South Henry Street, Madison.

B. M. Peckham, 344 University Hospitals, Madison.

E. O. Ravn, 925 Mound Street, Madison.

G. J. Stuesser, 205 South Mills Street, Madison.

Changes of Address

J. M. Lee, Madison, to Frederick, Maryland.

D. A. Peterson, Madison, to Waterville, Maine.

H. B. Christianson, Rochester, Minnesota, to Denver, Colorado.

L. E. Hughes, Eau Claire, to Minneapolis, Minnesota.

D. A. Emanuel, Madison, to Augusta.

D. A. Smith, Fond du Lac, to Milwaukee.

A. M. Kohn, Milwaukee, to Stevens Point.

George Light, Miami, Florida, to Milwaukee.

E. F. Senseny, Milwaukee, to Fort Wayne, Indiana.

J. L. Struthers, Milwaukee, to Wausau.

R. L. Baker, Beloit, to Champaign, Illinois.

R. S. Overton,** Honolulu, T. H., to Janesville.

J. K. Theisen, Fond du Lac, to Green Bay.

G. W. Savage, Milwaukee, to Appleton.

B. M. Zimmerman,** Warrington, Florida, to Milwaukee.

A. L. Settimi, Indio, California, to Milwaukee.

R. P. Reik, Milwaukee, to Brookfield.

D. S. Schuster, Madison, to Ann Arbor, Michigan.

B. F. Rahn, Cornell, to Chippewa Falls.

G. D. Miller, Milwaukee, to Oconomowoc.

P. L. Miller, Wood, to Racine.

G. S. Hogle, Madison, to Troy, Ohio.

Rhoda E. Johnson, Milwaukee, to Evanston, Illinois.

W. P. Quigley, Marshfield, to Brooklyn.

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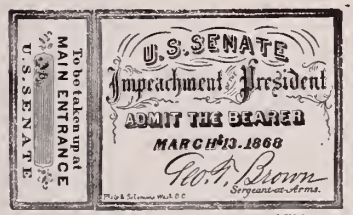
The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.
14. **Wisconsin Physicians Service Manual**—A guide for physicians and their office assistants in servicing contracts held by subscribers to the Blue Shield Plan of the State Medical Society of Wisconsin.

"I looked down into my open grave"



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"MR. SENATOR ROSS, HOW SAY YOU?"

In the deathly silence of the Senate chamber, the freshman Senator from Kansas looked down, as he put it, into his own grave.

On deliberately trumped-up charges, the bitterly fanatic leaders of Ross's party were trying to vote President Johnson out of office—because Johnson stood between them and their revenge on the defeated South.

Ross, they knew, also disliked Johnson and wanted to punish the South. But, taking no chances, they had warned him to vote "guilty" or face political suicide.

And now, on that historic May morning in 1868, the verdict had come to hang completely on his vote. First falteringly, then loudly, he gave it: "*Not guilty!*"

That was sheer moral principle speaking. Edmund Ross refused to join a move he thought would wreck the historic powers of the Presidency. For this, he lost his future, lost his good name, and saved for himself only what he had saved for everyone: our democracy.

Into the whole fabric of American democracy is woven the steel-tough moral fiber of men like Edmund Ross. Braver even than battle courage, it has helped America become strong in many ways. So strong, that, today, one of the world's greatest guarantees of security is U. S. Savings Bonds.

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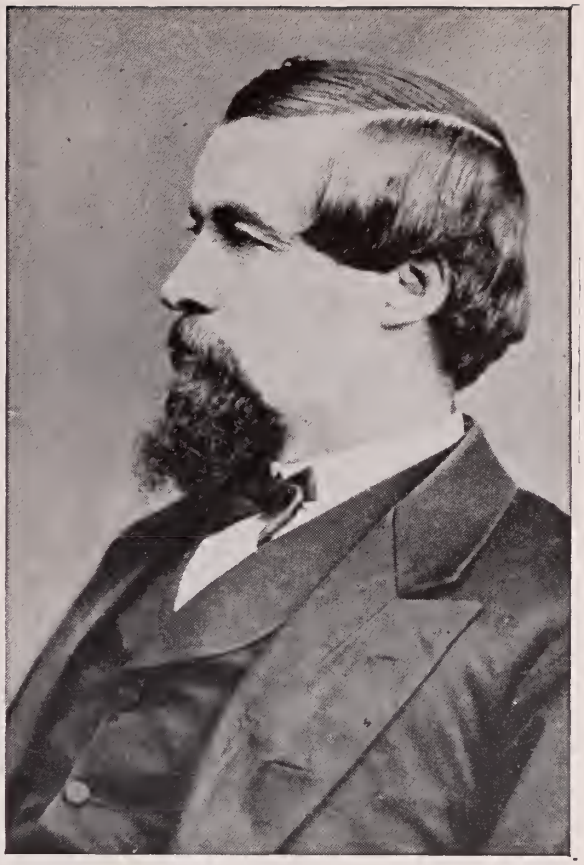

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OBITUARIES

Dr. Ralph O. Peterson died June 6 at his home in Racine after a long illness.

Doctor Peterson was born in Waupaca in 1884. He received his medical education at Marquette University School of Medicine, graduating in 1916.

Upon completion of his schooling, he located in Racine, where he continued his private practice for almost 40 years. He had retired from active practice in 1953.

He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American College of Surgeons.

Surviving are two sons, Rodney and James N., both of Racine; one brother, Harry L., of Waupaca; one sister, Mrs. Hugh Staffon, of Sheboygan; and one grandson and one granddaughter.

Dr. William H. Marshall, Milwaukee physician, died June 12 at a Milwaukee hospital after a long illness. He was 82 years of age.

Doctor Marshall had practiced medicine for 20 years in Chicago and 21 years in Beloit, specializing in obstetrics. He retired in 1947 when he became blind.

He was born in Cheraw, South Carolina, and attended Meharry Medical College in Nashville, Tennessee, after which he interned at Provident Hospital in Chicago and served a residency in obstetrics and gynecology at Northwestern University.

He is survived by his daughter, Nellie; one son, William, of Beloit; and two brothers and two sisters.

Dr. William O'Dwyer died June 15 in a Madison hospital. He was 78 years of age.

He had practiced medicine in Park Falls and in Dane before his retirement.

Surviving are his wife, Mary; one son, Joseph, Land O'Lakes; three daughters, Mrs. Earl Gleiter, Rio, Mrs. John Vodacek, Minong, and Mrs. Carl Babler, New York City.

Dr. Charles E. Bilstad, 82, died at his home on June 26, ending a 56-year career of active medical practice in Cambridge.

Doctor Bilstad had practiced in Cambridge since 1899, following his graduation from Northwestern Medical School, Chicago. He was born in the township of Pleasant Springs in 1873.

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He was a veteran of World War I, in which he served in the U. S. Army medical corps as a first lieutenant. He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin and its Fifty Year Club, the University of Wisconsin and Northwestern University half-century clubs, and the American Medical Association.

Survivors include his wife and three daughters, Gwen, at home; Ingeborg, in Santa Cruz, California; and Nellie, of Madison.

Dr. L. M. Lundmark, 77 years of age, died at his home in Ladysmith on June 30.

He was born in Denmark in 1879 and came to America with his mother in 1884, following the death of his father. They settled, at that time, in Cumberland, Wisconsin. After completing his medical education, he assumed a general practice in Ladysmith in 1904; and he practiced there until his death.

Doctor Lundmark contributed many "firsts" in medicine to his community, a few of them being: first chairman of local anti-tuberculosis association; first doctor to admit a patient, and first doctor to deliver a baby at the new St. Mary's Hospital; and first M.D. to install fluoroscope and x-ray equipment in his office. He was active in community affairs in Ladysmith and had served as city health officer. In 1951, two hundred friends gathered to honor him and offer testimonials.

He was a life member of the State Medical Society and held membership in his local Rock County Medical Society and in the American Medical Association. He was a member of the state society's Fifty Year club.

Doctor Lundmark is survived by his wife, Blanche, of Ladysmith and one daughter, Claire, of La Crosse.

At the age of 74 years, **Dr. Robert W. Blumenthal,** a widely known Milwaukee physician, died. His death occurred July 1 at a Milwaukee hospital after a long illness.

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HORMOGEN R-A (Rapid Action) combines the fast action of water-soluble Potassium Estrone Sulfate with the prolonged action of water-insoluble Estrone. Patient is gratified by the immediate relief and you have immediate insight into the effectiveness of the medication. Because of prolonged action, injections can be spaced 3 to 7 days apart.

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Doctor Blumenthal was graduated from the University of Illinois College of Physicians and Surgeons, Chicago, in 1904 and, after interning, began his private practice in Milwaukee in 1906. He had retired in 1950.

In World War I, Doctor Blumenthal was assistant division surgeon of the 32nd division, and later was assistant chief surgeon of the First American Army. He also served with the national guard on the Mexican border in 1916 and 1917. He was re-elected for his third consecutive term as surgeon general of the Veterans of the Mexican War in 1935.

Doctor Blumenthal was the editor of *The Milwaukee Medical Times* for more than 10 years. After World War II, he helped to compile *War Without Guns*, a book recording the contributions of Wisconsin physicians who served in the armed forces.

He was a member and past president of the Medical Society of Milwaukee County and a member of the State Medical Society of Wisconsin and the American Medical Association. He had served on the Council of the state society. He was a Fellow of the American College of Physicians and held membership in the Milwaukee Society of Internal Medicine.

Survivors include his wife, Lilian, Milwaukee; a daughter, Mrs. Louis Marick, Grosse Pointe Farms, Michigan; a brother, Leslie, Saint James, New York; and a sister, Mrs. Laurie C. Dickson, Charlotte, North Carolina.

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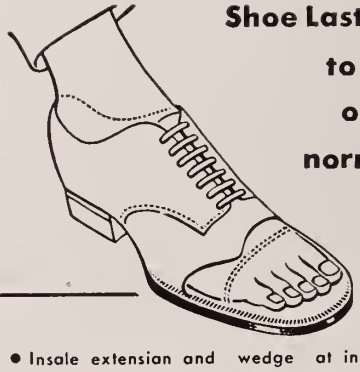

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1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

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THE JOURNAL BOOKSHELF

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical textbooks reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Truth About Cancer. By Charles S. Cameron, M. D., Medical and Scientific Director, American Cancer Society. Englewood Cliffs, New Jersey, Prentice–Hall, Inc., 1956. Price $4.95.

This is a timely book—and an important one.

It is timely because we are presently committing more and more of our resources to the fight against cancer, the disease that annually claims 160,000 American lives.

It is important because it presents the complete up-to-the-minute picture of the cancer problem—the good parts as well as the bad. And it presents the picture in terms that the layman can easily understand. But with all of its readability, it still retains the unmistakable stamp of scientific accuracy and of scientific integrity.

By its educational campaign of recent years, the American Cancer Society has rendered a yeoman service. It has alerted many people to the dangers of cancer and has brought countless patients to the offices of their family doctors for routine cancer checks. No one will accurately know how many cases of very early, curable cancer were detected and successfully treated as a result of this program, but even the most conservative estimates must put that number well into the thousands.

Of course there were criticisms—criticisms that the motivating power behind the campaign was fear, and that fear caused hysteria or cancer phobia.

No one can deny the validity of this argument, since it is obviously impossible to discuss a fearful subject without creating fear. But one can emphatically deny its importance by simply pointing out the fact that any large group contains a few immature and unstable individuals in whom fear itself becomes a disease. In these individuals, the explosive charge is all set and waiting for some spark to ignite the fuse. It makes little if any difference where the spark comes from. It could come from fear of heart disease as well as from fear of cancer or some other disease, from fear of environment, or from fear of circumstances.

As physicians, we would all like to think that our patients make their decisions on the bases of fact and reason, rather than on the nebulous bases of fancy and fear. But the human mind has not yet attained such a standard of perfection. Fear is still (and probably always will be) a powerful motivating force.

Our only weapon against fear is fact; and the more facts we can muster, the more powerful the weapon. But we must do even more. We must assemble the facts in the patient's mind. We must try to build a stereoscopic image with deep perspective. And last, but by no means least, we must help the patient set an accurate focus on the picture.

As far as the cancer problem is concerned, this has all been superbly accomplished by Doctor Cameron in *The Truth About Cancer.*

But he has gone even further. He has brightened the picture with hope. It is not the baseless hope of the starry-eyed dreamer, but rather the reasonable hope of a scientific man who is in a position to know what is going on in cancer research.

The Truth About Cancer is a timely and important book.

It is commended without reservation to all physicians and their patients.—L.G.K.

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THE MEDICAL FORUM

ACT TO CLARIFY, EXPEDITE DEPENDENTS MED CARE

North Central Group Meets to Learn, Discuss Full Details of New Law

ST. PAUL, MINN.—The State Medical Society of Wisconsin, as did similar organizations in eight other states, voiced their reactions to Public Law 569—Military Dependents Medical Care—at a special meeting of the North Central Conference Aug. 11–12.

The reactions related to the status of planning for putting the new legislation into working order by the Dec. 8 deadline. With representatives of the Department of Defense and the A.M.A., the Conference delegates expressed their views, asked questions and attempted to work out solutions to administrative, fiscal and fee problems.

In addition to Conference members from Iowa, Minnesota, Nebraska, North and South Dakota and Wisconsin, *Arkansas, Ohio and Washington* sent visitors to the session. Other meetings on the same subject involving Wisconsin officials have been held in Chicago and Prairie du Chien.

TIME FOR ACTION

Speaking for the Wisconsin delegation, which included 18 officers, Councilors and Commission on Prepaid Plan representatives, C. H. Crownhart, executive secretary of his society, said:

"This is a new challenge for the North Central Conference. Our contention is that dependents of servicemen should be treated medically by civilian physicians.

"Medicine is a personal service —not a commodity.

"The time has come when we can't wait for other states to do our drafting of plans, or for the government to do the job. Let's get to the root of the tree . . . to that level where we can do the most good.

THE PATIENT FIRST

"We must eliminate that type of arbitrary provision that considers the procedure before the patient. We don't expect a perfect program in six months. There'll be errors on our part, and on the part of the government. Constructive cooperation is vital.

"This plan could be a pattern which might possibly grow to effect millions of people."

Dr. E. M. Dessloch, Prairie du Chien, chairman of the Commission on Prepaid Plans in Wisconsin, said:

"In Wisconsin it is quite generally agreed that the home town care plan procedure would be most feasible, that our Society handle the administrative details with payment to physicians made at their usual, customary fees.

PATTERN VITAL

"We prefer to handle this program ourselves, as we handle Wisconsin Physicians Service.

"Time is of the essence. Our executive staff stands ready to work with all others to facilitate

(Continued on page 1030)

W. C. WHITE NAMED SPECIAL AIDE TO A.M.A. TASK FORCE

WASHINGTON — **William C. White**, assistant secretary of the State Medical Society of Wisconsin, has been named one of five technical consultants to the A.M.A. Task Force on Medical Care.

The first meeting of the consultants with the Task Force was held here Aug. 23.

Others named to the special committee were **John Steen**, Seattle, of the Washington State Medical Society; **R. W. Lyon**, Los Angeles, vice president of the California Physicians' Service; **S. A. Hildebrand**, Boston, comptroller of the Massachusetts Blue Shield Plan, and **George Farrell**, New York City, director of medical care insurance for the Medical Society of New York.

OK Improvised Hospital Units For C.D. Needs

FOND DU LAC—A unanimous recomendation that the State Civil Defense office accept a federal offer to supply Wisconsin with 12 **Improvised Hospital Units** was voted by the Society's Advisory Committee on Civil Defense Aug. 15.

Dr. Carl N. Neupert, State Health Officer, was told to inform Adj. Gen. Ralph J. Olson, in charge of civil defense for Wisconsin, that effective utilization could be made of the units in the vicinity of Milwaukee, the state's designated critical target area. Such problems as storage, location and manning will be worked out satisfactorily, Dr. Neupert was assured.

The Federal Civil Defense Administration recently offered to allot one unit for each 100,000 population in critical target areas. The population in counties surrounding Milwaukee has been estimated at 1,250,000.

Each unit consists of 200 portable beds, an x-ray facility, operating tables and equipment, a shock treatment room, a pharmacy and registration facilities. Each unit is valued at more than $25,000.

Drs. S. A. Graiewski, Oshkosh; J. S. Wier, Fond du Lac, and Arthur L. Van Duser, Madison, said both the professional and laymen personnel of the unit teams could be worked out on a local level, with the cooperation of county medical societies.

Also attending the meeting were **Frank Madson**, business manager of Dr. Graiewski's mobile medical team in Oshkosh, and **Theodore Noe**, assistant co-director of health services in civil defense.

* * *

(Full details of Wisconsin's civil defense efforts to date, roster of mobile medical teams and importance of being prepared may be found in inside pages of the Forum this issue.)

PHYSICIANS' ROLE IN CIVIL DEFENSE VITAL

Madison—Wisconsin physicians are getting ready for civil defense.

It's a monumental task, organizing 108 medical teams, and the goal hasn't been reached yet.

Theodore Noe, assistant co-director of health services and civil defense for the Wisconsin State Board of Health, who was given the chore of setting up the working units, commented:

"We've organized 45 teams during the past 18 months. Until recently, the big hitch was lack of interest and coordination.

"When the local county medical society gets behind the project, good teams result.

"But I'm enthusiastic. Things are moving, albeit slowly. I realize it's going to take a long time. Sometimes it's like hitting your head against a wall, but if you do that long enough, some cracks will show and you'll penetrate somewhere.

"The doctors are sincere, but like other people, are apathetic and say 'In case of an emergency, if the need arises, we can take care of the people.' Some of them, however, see the urgency for action now."

The teams, consisting of 29 members, are led by a captain and deputy officer, both physicians. Noe said they need give only two or three hours per month for educational instruction of team members until fully organized, and then only several hours a year to keep in readiness.

"These can't be 'paper' teams," Noe said. "They must be set up right, must practice and keep organized. It has to be assembly line medicine, of the kind expected to save thousands of lives after a bomb attack."

DR. VINCENT W. NORDHOLM, deputy officer of Team 115 in Dane County, is shown above (right) checking supplies at the Elkhorn alert center. Nordeen Offerdahl, also of Stoughton, assisted in preparing surgical instruments and medical supplies. *(Milwaukee Journal Photo)*

The State Medical Society's Committee on Civil Defense, with **Dr. E. P. Ludwig** of Wausau, chairman, has contributed much to the organization of the Wisconsin program and keeps a vigilant eye on activities and projects. Other committee members include **Drs. E. A. Bachhuber,** Milwaukee; **S. J. Graiewski,** Oshkosh; **J. S. Wier,** Fond du Lac and **D. L. Williams,** Madison.

Noe praised the excellent efforts of a number of county societies in preparing for an emergency. **Brown County,** he said, was asked to line up seven teams, *"and it has seven teams . . . certainly one of the best set-ups . . . thanks to the local medical society."*

He also commended the efforts of the **Dane County Medical Society,** which has eight of 12 teams in action; **Marathon County,** with three, its allocation; **Racine,** with six of eight; **Walworth,** with two of two, and **Sheboygan,** with all four doing a good job.

What are the areas in which organization of the teams is moving slowly?

"Milwaukee County is one," Noe explained. "We assigned 10 teams to that area, and there is none in operation yet. I don't know how things are going to be worked out there.

"Other counties with teams only on paper include Door, Douglas, Eau Claire, Jefferson, Monroe, Oconto, Outagamie, Portage and Shawano. Wood County has a unit, but at the moment it lacks a physician-captain."

DR. JACK PETERSON, Waupun, captain of Wisconsin Civil Defense Team 324B, completes bandaging a "casualty" at the alert center in Plymouth. Above (right), the physician headed a team which ran through a smooth drill and showed its readiness for an emergency event.

STRIKES HOME

(It's interesting to note that interest in civil defense in eastern Wisconsin picked up markedly after a tornado struck Berlin and environs in Green Lake County last spring, resulting in heavy property damage and loss of several lives.)

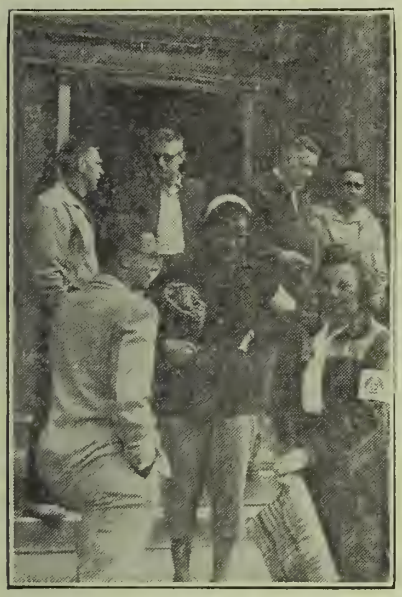
The Federal Government has designated **Milwaukee** as a critical bomb target area, and **Green Bay, Kenosha, Madison, Racine** and **Superior** as primary target locations.

DR. CARL N. NEUPERT, State Health officer, commented:

"The Elkhorn demonstration clearly showed that equipped, well-trained mobile medical teams can be moved expeditiously to a scene of disaster and that on arrival they can get underway promptly in caring for the injured.

"The teams were certainly impressive as they went into action, each member in his assigned role. It was most inspiring to see doctors, dentists, nurses and others respond to the need as responsible citizens by devoting a Sunday, plus the time spent in training, to be ready to serve the suffering in time of need."

"BOMB" VICTIMS TREATED BY ASSEMBLY LINE MEDICS



TEAM 347C, headed by Dr. Henry J. Winsauer, Sheboygan, assembled at Sheboygan for its alert action at Plymouth. Dr. Winsauer (front, left) is shown mapping plans with several members of his team before a bus arrived to drive the team to the center of operations.

"Operation Alert 1956" Proves Successful Trial

By HARRY S. PEASE
Of The Milwaukee Journal Staff

ELKHORN, WIS. — Assembly line medicine, of the kind expected to save thousands of lives after a bomb attack, was demonstrated impressively here July 22.

Three teams, organized under the State Civil Defense office and the State Board of Health, rolled into the national guard armory and set up a casualty clearing station. In slightly more than an hour, they examined, bandaged and splinted more than 76 "wounded."

One team, commended by Dr. R. F. Schoenbeck, came from Stoughton. Another, commended by Dr. John E. Martin, came from Delavan. The third, led by Dr. E. D. Hudson, came from Lake Geneva.

PART OF OPERATION ALERT

Three others put on a similar demonstration at Plymouth. The teams wound up Wisconsin's participation in Operation Alert 1956, a national CD drill.

Walworth County, with a population of about 45,000, has 11 regular rescue squads with ambulances and emergency equipment. All made at least brief appearances at the drill.

The "casualties" were Boy Scouts from the county. On arrival, they checked past a row of card tables where they were registered and where each received a tag of the type a rescue worker might hang on him in a real disaster.

Let's follow Allan Russell, 12, of Walworth, through the treatment. His tag read, *"First degree burns on face. Simple fracture, right foot."*

CONDENSED RECORD

The tag is a model of condensed record keeping. About 3 by 5 inches in size, it has space for comments on one side and outline drawings of the human body on the other, so that an unskilled rescuer who does not know how to describe an injury can mark its location quickly.

The comment side bears a serial number; space for name, address, sex and age of the casualty; where the victim was when he was hurt; where he was found by rescuers; treatment given by first aid worker; treatment at the casualty station, and disposition of the case.

Allan reported first to the collecting station outside the armory. There, first aid workers

(Continued on page 1026)

EDITOR'S NOTE

The accompanying article appeared in *The Milwaukee Journal* July 23, 1956. It is being reprinted in the *Medical Forum* with special permission.

To get teams alerted, a telephone call is made from the State Civil Defense office to each medical team captain. He in turn calls his deputy officer and business manager, who call other team members. In some communities, a special fire whistle or siren call is sounded. Transportation to the scene of action — in buses — is provided by the state. Pick-up trucks are also used in the roundup. State highway patrolmen serve as escorts.

It's a matter of preparation, teamwork and speed.

After its first warning, the Stoughton team moved 65 miles to Elkhorn in 2 hours, 28 minutes. County truck highways were used over much of the route, because there is no through road. The Waupun and Oshkosh teams made the 42 miles to Plymouth in less than two hours after the alert sounded. The Lake Geneva team, with only seven miles to go, rounded up its team and reached Elkhorn in 75 minutes.

Recommended viewing: *"The Flash of Darkness"*—a 28 minute, black-white, color film available from the State Medical Society office or from Theodore Noe, c/o State Board of Health, Madison.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

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	BATTALION I
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Team 102 (Sauk)	Captain, DR. A. C. EDWARDS, Baraboo Deputy Officer, DR. JOHN BOOHER, Reedsburg
Team 103 (Green)	Captain, DR. N. E. BEAR, Monroe Deputy Officer, DR. C. EARL BAUMLE, Monroe
Team 105 (Rock)	Captain, DR. GEORGE METCALF, Janesville Deputy Officer, DR. MILTON J. DONKLE, Janesville
Team 109 (Dodge)	Captain, DR. ROGER I. BENDER, Beaver Dam Deputy Officer, DR. AMBROSE KORES, Beaver Dam
Team 113 (Dane)	Captain, DR. EUGENE J. NELSON, Sun Prairie Deputy Officer, DR. JOSEPH F. BEHREND, Sun Prairie
Team 114 (Dane)	Captain, DR. LUTHER E. HOLMGREN, Madison Deputy Officer, DR. JOHN R. STEEPER, Madison
Team 115 (Dane)	Captain, DR. R. F. SCHOENBECK, Stoughton Deputy Officer, DR. V. W. NORDHOLM, Stoughton
Team 116 (Dane)	Captain, DR. ARCH E. COWLE, Madison Deputy Officer, vacancy
Team 118 (Dane)	Captain, DR. THEODORE J. NEREIM, Madison Deputy Officer, DR. JOHN A. SALICK, Madison
Team 120 (Dane)	Captain, DR. ROBERT M. BECKER, Madison Deputy Officer, DR. RICHARD C. WIXSON, Madison
Team 121 (Dane)	Captain, DR. DAVID L. WILLIAMS, Madison Deputy Officer, DR. LEE B. STEVENSON, Madison
	BATTALION II
Team 202 (Kenosha)	Captain, DR. DAVID N. GOLDSTEIN, Kenosha Deputy Officer, DR. JAMES J. LUTZ, Kenosha
Team 205 (Ozaukee)	Captain, DR. GEORGE F. SAVAGE, Port Washington Deputy Officer, DR. ARNOLD H. BARR, Port Washington
Team 207 (Walworth)	Captain, DR. JOHN E. MARTIN, Delavan Deputy Officer, DR. WILLIAM C. WOODS, Delavan
Team 208 (Racine)	Captain, DR. LIEF W. ERICKSON, Burlington Deputy Officer, DR. LEE V. KEMPTON, Burlington
Team 209 (Waukesha)	Captain, DR. JOHN L. CLAUDE, Oconomowoc Deputy Officer, DR. PETER THEOBALD, Oconomowoc
Team 212 (Walworth)	Captain, DR. E. D. HUDSON, Lake Geneva Deputy Officer, DR. BOYD C. KINDALL, Lake Geneva
Team 214 (Racine)	Captain, DR. ARTHUR J. JACOBSEN, Racine Deputy Officer, vacancy
Team 215 (Racine)	Captain, DR. JOHN G. JAMIESON, Racine Deputy Officer, DR. ALBIN J. SCHLEPER, Racine
Team 216 (Racine)	Captain, DR. HARRY AGELOFF, Racine Deputy Officer, DR. HAROLD C. HILKER, Racine
Team 217 (Racine)	Captain, DR. RICHARD J. MAYER, Racine Deputy Officer, DR. JOSEPH D. POSTORINO, Racine
Team 218 (Racine)	Captain, DR. C. R. NEWMAN, Racine Deputy Officer, DR. RICHARD MINTON, Racine
	BATTALION IIIA
Team 301A (Brown)	Captain, DR. GERALD B. MERLINE, DePere Deputy Officer, DR. BERNARD P. WALDKIRCH, DePere
Team 302A (Brown)	Captain, DR. CLARENCE A. ROTHE, Green Bay Deputy Officer, DR. FABIAN J. GOSIN, Green Bay
Team 303A (Brown)	Captain, DR. JAMES F. McDERMOTT, Green Bay Deputy Officer, DR. HARRY H. DANAHER, Green Bay
Team 304A (Brown)	Captain, DR. JOHN E. DETTMANN, Green Bay Deputy Officer, DR. STEPHEN D. AUSTIN, Green Bay
Team 305A (Brown)	Captain, DR. E. R. KILLEEN, Green Bay Deputy Officer, DR. C. J. HIPPS, Green Bay
Team 306A (Brown)	Captain, DR. BERNARD KULKOSKI, Green Bay Deputy Officer, DR. DONEL SULLIVAN, Green Bay
Team 307A (Brown)	Captain, DR. ROBERT J. ROSE, Green Bay Deputy Officer, DR. JOHN L. FORD, Green Bay
Team 312A (Marinette)	Captain, DR. CLARK H. BOREN, Marinette Deputy Officer, DR. PHILLIP R. McCANNA, Marinette
	BATTALION IIIB
Team 323B (Fond du Lac)	Captain, DR. WILBERT E. MYERS, Fond du Lac Deputy Officer, vacancy
Team 324B (Fond du Lac)	Captain, DR. JACK PETERSON, Waupun Deputy Officer, DR. HARMON H. HULL, Waupun
Team 326B (Winnebago)	Captain, DR. S. J. GRAIEWSKI, Oshkosh Deputy Officer, DR. VERNON GUENTHER, Oshkosh
	BATTALION IIIC
Team 342C (Manitowoc)	Captain, DR. RUSSELL G. STRONG, Manitowoc Deputy Officer, DR. DANIEL M. PICK, Manitowoc
Team 345C (Sheboygan)	Captain, DR. HARRY H. HEIDEN, Sheboygan Deputy Officer, DR. W. G. HUIBREGTSE, Sheboygan
Team 346C (Sheboygan)	Captain, DR. A. J. BRICKBAUER, Plymouth Deputy Officer, DR. LLOYD J. STEFFAN, Plymouth
Team 347C (Sheboygan)	Captain, DR. HENRY J. WINSAUER, Sheboygan Deputy Officer, DR. ROMAN C. PAULY, Sheboygan
Team 348C (Sheboygan)	Captain, DR. J. L. WEYGANDT, Sheboygan Falls Deputy Officer, DR. DAVID A. WERNER, Sheboygan Falls
	BATTALION IV
Team 401 (Marathon)	Captain, DR. BURTON K. SMITH, Wausau Deputy Officer, DR. ROY B. LARSEN, Wausau
Team 402 (Marathon)	Captain, DR. ALBERT H. STAHMER, Wausau Deputy Officer, vacancy
Team 403 (Marathon)	Captain, DR. CHARLES M. BALLIET, Wausau Deputy Officer, DR. GEORGE J. SCHROTH, Wausau
	BATTALION V
Team 501 (La Crosse)	Captain, DR. MARK T. O'MEARA, La Crosse Deputy Officer, DR. ROBERT L. GILBERT, La Crosse
	BATTALION VI
Team 605 (Chippewa)	Captain, DR. EARL A. HATLEBERG, Chippewa Falls Deputy Officer, DR. BRUNO J. HAINES, Cadott

"BOMB" . . .

(Continued from page 1025)

checked quickly for severe bleeding which might call for emergency action. The card did not indicate any, so he was moved inside.

The stretcher on which he was carried is a khaki army type that stands on its own short legs. Each CD team has 25, and the state office has more in storage dumps.

TREAT FIRST, ASK LATER

Allan was carried to the Stoughton team. At that time none of the blanks on his card, other than the list of injuries, was filled out. Treat the hurts, *then* ask the questions, was the order of the day.

Dr. Schoenbeck headed the sorting unit. One of the most important, and difficult, parts of medical practice is determining what is wrong and what should be done about it.

On the sorting team with the doctor was Mrs. Clara Wersland, chief surgical nurse at the Stoughton hospital. Had this been the real thing, a prolonged examination might have been necessary. Since it was not, a quick reading of the card sufficed.

"Take him to the surgical and shock units," Dr. Schoenbeck told the stretcher bearers.

INSTRUMENTS READY

Still on the stretcher, Allan was laid gently on the floor between two tables over which Dr. Vincent W. Nordholm, Stoughton, presided.

On the surgical table were laid out ranks of shiny instruments—scissorlike hemostats to pinch off blood vessels, scalpels to clear away hopelessly damaged tissue, retractors to hold open the gaping wounds so Dr. Nordholm could make deep repairs.

Among his aides were two dentists—*Dr. F. B. Henderson* and *Dr. Lloyd Skallen.* Dr. Henderson in particular had considerable experience in dealing with battle casualties. He was chief of dental service for the 93rd Army Station Hospital in Africa and Italy during World War II, and that was the hospital which cared for the wounded of the army's first victory in the African fighting.

TOGETHER TWO YEARS

The other assistants were just plain people. Nordeen Offerdahl is a furniture salesman. Alden Heg-

(Continued on next page)

IN ACTION at Plymouth—Two medical leaders of the Oshkosh CD team, Drs. S. J. Graiewski (at center rear, wearing helmet) and Vernon G. Guenther (second from left) keep things moving at the alert center.

gestad is a postal clerk. DuWayne Webb is a mechanic and parts department manager at a farm machinery company. Harold Ringer is a millwright.

They went to work on Allan. His whole head was swathed in soft dressings and covered with firm bandages, with snipped out openings for eyes, nose and mouth.

Dr. Nordholm took care of the foot himself, strapping the "broken" bones into place.

Only after his injuries were treated was Allan's record complete. The tag would have stayed on him for the long trip to a hospital in some undamaged part of the state.

At the rate casualties were handled Sunday, the supplies would have had to be replenished within three hours or so.

BLOOD NEEDED

There would be problems in medical care, Dr. Nordholm noted. The lighting in the armory was not what a surgeon would wish for. The water supply was sharply limited.

"We'd need loads of antibiotics —penicillin and the like," he said. *"Under these conditions you simply could not practice the usual sterile techniques, and you would have to depend on fighting infection other ways."*

Blood for transfusions would also be needed, the physician added, though the unit has supplies of plasma and chemical substitutes for it.

To Circulate AMA Hospital Report

MADISON—County medical society secretaries and chiefs of staff of all general hospitals in Wisconsin will soon receive a report of the AMA's position on accreditation of hospitals.

At its meeting in Land O'Lakes in July, the State Medical Society's General Council approved a recommendation of the Council on Medical Service and the Committee on Hospital Relations to circulate the material. The report constitutes recommendations to the *Joint Commission on Accreditation of Hospitals.*

The Council also approved a survey of physician-hospital relations by the Council on Medical Service and the Committee on Hospital Relations. The survey will be conducted this fall.

ON THE S.M.S. CALENDAR . . .

SEPTEMBER

16–18—Wisconsin Chapter, American Academy of General Practice, Milwaukee
21—Basic Science Board Examinations, Madison
22–23—Clinic Managers, Madison
26–28—National Blue Shield Medical Care Plans, Asheville, N. C.
27—Fifth District Meeting, Hartford

OCTOBER

2—Claims Committee, S.M.S.
9—Circuit Program, Green Bay
10—Circuit Program, Menominee, Mich.
10—Wisconsin Commission for Improvement of Patient Care, Milwaukee
11—Circuit Program, Wausau
18—Conference on School Health, Whitewater
19—State Board of Medical Examiners, Madison
22—National Blue Cross–Blue Shield Workshop Conference, Chicago

NOVEMBER

6—Claims Committee, S.M.S.
10–11—North Central Conference, St. Paul
15—Conference on School Health, Superior
25—Executive Commission, National Blue Shield Plans, Seattle
27–30—AMA Clinic Session, Seattle
27—Circuit Program, Lancaster
28—Circuit Program, Janesville
29—Circuit Program, Appleton

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PREDICT DOCTOR DRAFT LAW TO END JUNE 30, 1957

Physicians' Eligibility for Regular Draft Left Unchanged

MADISON—Everything points to the end of the Doctor Draft in July, 1957.

In a recent exclusive interview with *Medical News*, a tabloid newspaper for physicians, Dr. Frank B. Berry, Assistant Secretary of Defense in Charge of Medical Affairs, reported:

"The way things are now going, we will not ask for an extension of the special law to draft doctors."

If the special Doctor Draft Law expires next year on June 30, physicians who currently face military service in Priorities I and II will be relieved of that obligation. However, physicians will then be eligible for the draft as regular registrants.

Obviously, in event of a shooting war or an inability to obtain as many physicians as anticipated, the Doctor Draft my be reinstated. And physicians previously in Priorities I and II and not called, may find themselves facing another period of uncertainty as to military service.

NEEDS ARE MET

The big factor in the end of the Doctor Draft is the fact that 1956–57 will see the graduation of enough non-veteran M.D.'s to fill most U. S. military needs. At present, the armed forces need about 9,600 physicians in uniform to care for the nearly 3,000,000 members of the armed forces. The military has been drafting about 7,000 doctors every two years to bolster the hard core of the medical corps. These are taken in alternating groups of 5,000 and 2,000.

With the end of the Doctor Draft in 1957, the armed forces expect to get their 7,000 physicians through such regular channels as the armed forces intern and residency training programs, the medical-senior-dental programs and the regular draft.

The military forces residency deferment program has selected 900 physicians for deferment in 1956 and 1,000 next year.

PATTERN OUTLINED

By July, 1958, the first 300 deferred residents will complete their training and enter the armed forces. In the following year, there will be 900 entering the service; and each year thereafter, about 1,000. It is planned that these men will provide the nucleus of well-trained specialists which is needed to augment the relatively non-experienced graduating physicians who enter the service immediately after internship.

The end of the Doctor Draft is being aided by efforts of the armed forces to make medical service more attractive. A new career incentive bill for medical officers offers $100 to $250 a month extra pay. Also, there are improved promotion policies, improved assignment policies and voluntary retirement after 20 years' service.

DUTIES QUESTIONED

These developments would appear to be aimed at eliminating common criticisms of military service by physicians in recent years. Typical of the comments of Wisconsin physicians who recently completed service under the Doctor Draft Law is one from a psychiatrist who said he "spent most of my time screening recruits at a training center, and the work I did certainly did not require an M.D."

A Milwaukee general practitioner reported he was **"properly placed in military service but spent a considerable amount of my time doing administrative work."** He added:

"The army could have given more of those administrative duties to the Medical Service Corps because there were times when medical work had to cease in order to accomplish the administrative job."

"TRIVIAL, BORING"

Another physician reported his 16 months in Korea as **"boring—sick calls were invariably trivial and uninspiring, requiring little or no diagnostic ability. After 16 months, I was sent to a station where overloading of patients was common, especially among dependent care, necessitating cutting short or cursorily examining GI's so as to be able to see and treat the dependents."**

The recently-passed legislation providing civilian care in part for dependents of military personnel may serve to alleviate the need for physicians to care for dependents in military installations. At least there are prospects that this type of service will be reduced.

SUBSIDY PLAN POPULAR

The junior-senior medical student subsidy program is proving highly popular. The program provides for the commissioning of these students as second lieutenants or ensigns. Each student so commissioned is placed on active duty status with full pay and allowances approximately $4,000 annually, depending on the size of his family.

This continues until *completion of the academic requirements for his medical degree.* He has *no* other duties than his regular medical school curriculum, but all applicants must agree to accept an appointment as a first lieutenant in the Army or a regular commission, if offered, in the Navy upon graduation and to serve three years' active duty immediately following internship.

Seek Division of Brown–Kewaunee–Door Medical Society

LAND O'LAKES—A request of the Brown–Kewaunee–Door County Medical Society to divide into separate organizations was endorsed by the State Medical Society's General Council at its recent meeting.

Physicians in the three counties seek to divide the one society into the **Brown County Medical Society** and the **Kewaunee–Door County Medical Society.**

Final approval to the division must be given by the House of Delegates.

Dr. Houghton

Dr. J. H. Houghton Named to Council

LAND O'LAKES—Dr. John H. Houghton, Wisconsin Dells, was elected to the Council of the State Medical Society July 28.

A graduate of the Marquette University School of Medicine, the new councilor succeeds *Dr. H. E. Kasten,* Beloit, who was named president-elect of the Society in May.

With Dr. N. A. Hill of Madison, Dr. Houghton will represent the medical societies of Columbia, Adams, Dane, Green, Marquette, Sauk and Rock counties.

The Council also urged the development of legislation to boost the number of physicians on the Medical Advisory Committee to the State Motor Vehicle Department.

Means to carry out provisions of a proposed U.S. Dept. of Defense program to provide medical and surgical care for dependents of servicemen were explored. The legislation, enacted in June this year, will affect an estimated 30,000-50,000 Wisconsin servicemen and their families.

The new program, still in progress of preparation for needs and situations in the various states and territories, has A.M.A. endorsement.

New Films

"On Impact"—a 15 minute motion picture on the part played by the medical profession in prevention of auto crash injuries. Available from the Chicago office of A.M.A., the Ford Motor Co., Detroit, or S.M.S. in Madison.

"The Case of the Doubting Doctor"—a half hour film on services and activities of the A.M.A. Available from the A.M.A. or S.M.S.

Council OKs Policy on M.D. Advertising

LAND O'LAKES—Several statements of policy relating to ethical means of advertising by physicians were adopted by the State Medical Society's General Council at its meeting here in late July.

The Council adopted a recommendation of the Society's Grievance Committee that *"newspaper advertisements, cards or announcements as to the availability of vaccine against poliomyelitis in a particular doctor's office, even for his own patients, is of questionable ethics and can be both misleading and confusing to the public."*

Concerning the use of space in the classified section of a telephone director, the Council recommended that **"there be no use of the classified section of a telephone directory in any manner not approved by the local county medical society involved."**

The Council also declared that "when use of the classified section is contemplated outside of the county medical society area of those intending such action, the approval of the society thus involved must be obtained."

Dr. M. H. Olson to Attend W.M.A. Session

MADISON — Dr. Marvin H. Olson, Wittenberg, has been invited by the Secretary-General of the World Medical Association, Dr. Louis Bauer of New York City, to attend the Secretariat Liaison meeting to be held in New York City in October.

The meeting will follow the 10th General Assembly of the Association in Cuba.

Dr. Olson addressed the first meeting of the United States Committee of the W.M.A. in Chicago this summer, speaking on *"The Importance of the Association to World Medicine."*

He said W.M.A. is contributing to world peace, is offering an opportunity for international exchange of physicians and is **"truly the watchdog of free medicine throughout the free world."**

Listen to the "March of Medicine" on any one of 42 Wisconsin radio stations every week.

DR. F. X. POMAINVILLE, Wisconsin Rapids physician, was presented a certificate of merit from the State Medical Society on his 85th birthday in August. The Riverview Hospital staff also presented him with a cake. Making the presentations were Drs. O. A. Backus (left), Port Edwards, and R. E. Garrison (right), Wisconsin Rapids, who is Councilor for the 9th District. *(Wis. Rapids Tribune Photo)*

Council Honors Dr. Pomainville

LAND O'LAKES—A resolution praising **Dr. F. X. Pomainville,** Wisconsin Rapids, for *"more than 40 years of outstanding public service as a health officer,"* was adopted by the Council at its summer meeting.

Affectionately referred to in his home community as "Doctor F.X.," the physician was also cited for his excellent record in medical practice, which began in 1899.

EXEMPLARY RECORD

He has served as president of the Wood County Medical Society, a member of the medical corps in World War I, and as mayor of Wisconsin Rapids.

Dr. Pomainville became a life member of the State Medical Society in 1949.

Dr. Mason on District Committee

CHICAGO—**Dr. Paul B. Mason,** of Sheboygan, Wis., has been appointed a member of the special Committee on Constitution and By-Laws of the Blue Shield Medical Care Plans.

Dr. Mason is commissioner of the 10th District for Blue Shield, comprising Wisconsin, Iowa, South Dakota, Minnesota, North Dakota and Nebraska.

He also is a member of the State Medical Society of Wisconsin's Commission on Prepaid Plans.

DEPENDENTS . . .

(Continued from page 1023)

this operation. The pattern of this program may be a pattern of other things to come. It is very important to medical economics.

"We are giving this very serious consideration; we have definite ideas. We will help in every way possible."

Mr. Crownhart also made a plea to A.M.A. representatives to *"perfect the organization's lines of communications to state medical societies."* He said:

"Work to keep the societies fully informed. We must know what's transpiring. What may not be important to you may be important to us. I am referring to the documents, the reasoning, the actions."

Frank A. Bartimo, DOD counsel who came from Washington, D. C., for the meeting, said it was the purpose of the DOD task force devising the mechanism for the program to provide fringe benefits for servicemen's dependents, as a *"morale boost."* He explained:

SIMPLE, REASONABLE

"We're for free enterprise. We want to maintain U.S. medicine as the greatest in the world. Industry has gone even further than this new law. We want it to be simple and economical. We want to keep out government red tape. There'll be lots of nuts and bolts, but we're happy in that the climate of opinion and the general thinking on this is starting to jell."

Bartimo assured the delegates that physician bills would be paid promptly, with DOD handling all instances of misrepresentation or fraud. He said he did not contemplate any major headaches or problems in accepting the fee schedules submitted by the various state societies.

Also participating in the meeting were Col. Robert Benford, M. D,. air force medical officer who serves as a member of the DOD Task Force, and Gen. W. J. Kennard, M. D., assistant director of the A.M.A. Washington office.

Resolutions approved by the Conference included:

1. Urging each society to expedite action for assuming full responsibility for the Dependents Medical Care program and to designate a fiscal agent for administration purposes.

2. Establishing a temporary committee to develop recommendations to member groups, to the A.M.A. Board of Trustees and the Secretary of the Army as to contract provisions relating to handling of claims, reimbursement to states for medical bills paid, statistical and accounting reports, coding and other regulations.

3. Requesting the A.M.A. to secure and transmit to state societies claim and other administrative procedures, coding and forms in progress drafts as developed by the DOD and the Secretary of the Army.

FEES A CONCERN

4. Requesting the A.M.A. to investigate feasibility of establishing a corporation or other agent to serve as a fiscal agent for the states in administration of the program, if the government wishes to operate through this device. It was felt that state societies could operate in that capacity on an area basis.

5. Urging societies to consider and 32 per cent operated by fedthe basis of usual, customary physician charges in their medical communities.

6. Recommending to the DOD and Army Secretary that the 150 most common medical procedures be separately established as the basic fee schedule, to expedite the program.

In addition to Dr. Dessloch, other Wisconsin representatives at the gathering included:

Drs. **E. L. Bernhart**, immediate past-president of the Society; **Richard Foregger, W. T. Casper, N. J. Wegmann** and **J. P. Conway**, of Milwaukee; **J. C. Fox** and **F. H. Wolf**, La Crosse; **L. H. Lokvam**, Kenosha; **H. E. Kasten, Beloit**, president-elect of the State Medical Society; **L. O. Simenstad**, of Osceola, Society president; **R. E. Garrison**, Wisconsin Rapids;

Paul B. Mason, Sheboygan; **Robert Krohn**, Black River Falls; **Albert W. Hilker**, Eau Claire; **H. A. Aageson**, Oconto; **R. G. Arveson**, Frederic; **J. H. Houghton**, Wisconsin Dells and **Milton Finn**, Superior.

The Drug Store Is Vital (49)

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Proof of this statement is given in the following table. This table shows what percent of our country's total medical supply is handled by the leading types of outlets:

Drug Stores	66.8%
Hospitals	22.1%
Physicians	3.7%
Government, and All Other	7.4%
	100.0%

Obviously, the drug field is more important—by far—than all the other outlets put together.

DAN RENNICK
Editor of American Druggist

A MOUNTAIN OUT OF A SMALL PILL—The American Druggist magazine of June 18, 1956, provides a clear answer to charges that physicians dispense and distribute too high a proportion of the nation's drug supply. The druggists' publication chart shows less than 4 per cent of the drugs and medicines distributed in America are handled by doctors of medicine!

DR. BURNEY NAMED SURGEON GENERAL

WASHINGTON—Dr. LeRoy E. Burney, former Indiana State Health Commissioner, has been named by President Eisenhower as surgeon general of the U.S. Public Health Service.

The appointment is subject to senate confirmation next year.

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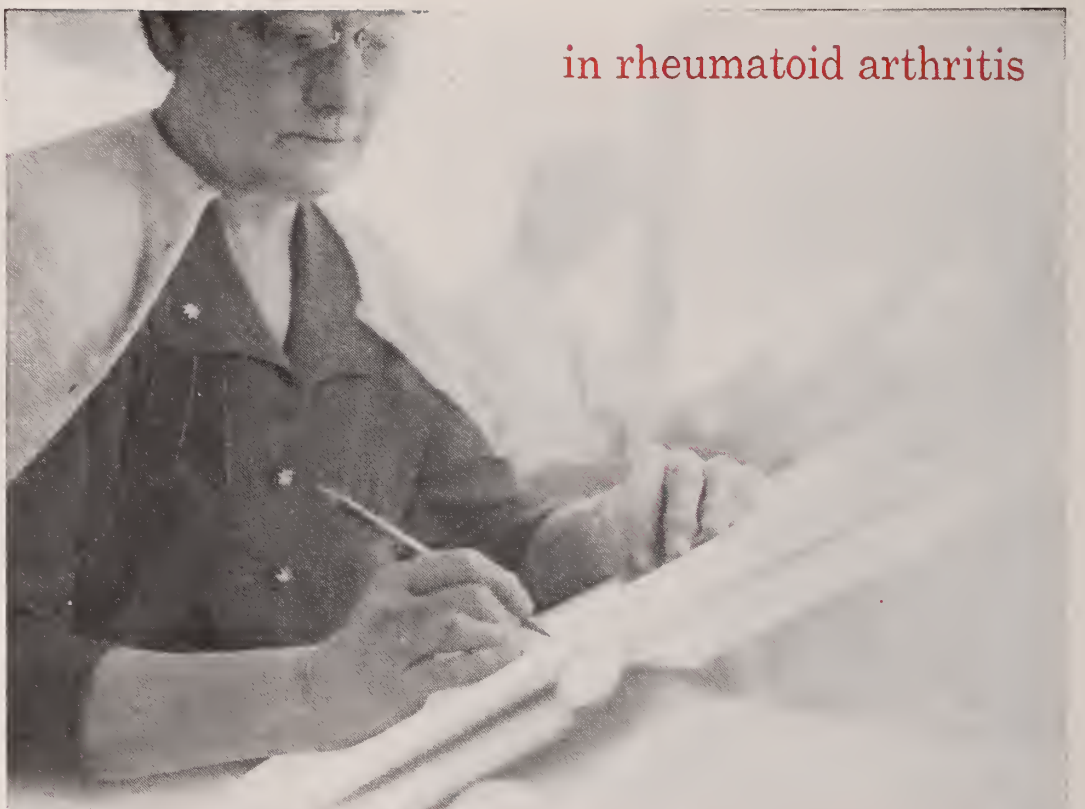
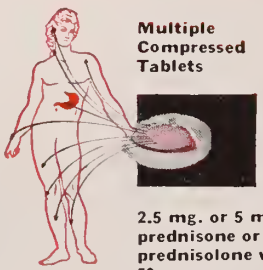


in rheumatoid arthritis

clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Prednisolone Buffered)



Multiple Compressed Tablets

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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plus positive antacid action
to minimize gastric distress

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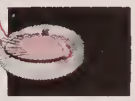

'Co-Hydeltra'
(Prednisolone Buffered)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

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Advertisements for this column must be received by the 15th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Electrocardiograph, direct writer. Jones Basal Unit, $125. Ultrasonic Unit, almost new. FCC-approved Short Wave, 30 MA X-ray Unit, almost new, greatly reduced. New Vertical Film File. Address replies to C. C. Remington Co., 1204 W. Walnut St., Milwaukee 5, Wis.

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1. Moser, M.: New York State J. Med. 55:1999 (July 15) 1955. 2. Agrest, A., and Hoobler, S.W.: J.A.M.A. 157:999 (March 19) 1955. 3. Smirk, F.H.: Am. J. Med. 17:839 (Dec.) 1954. 4. Smirk, F.H., and McQueen, E.G.: J. Chron. Dis. 1:516 (May) 1955. 5. Waldman, S., and Pelner, L.: Am. J. M. Sc. 231:140 (Feb.) 1956.

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	938, 939
American Meat Institute	949
Atlas Pharmaceutical Laboratories	1010
Ayerst Laboratories	954
Baker Laboratories	952
Barr X-Ray Company	1037
Bayer Company	943
Benson Optical Company	1019
Breon, George A., & Company	941
Brown and Williamson Tobacco Corp.	948
Burroughs Wellcome & Co., Inc.	942, 946, 957
Ciba Pharmaceutical Products	1013
Cook County Graduate School of Medicine	1014
Davies, Rose & Co., Ltd.	1015
Doerflinger Artificial Limb Co.	937
Endocrine Laboratories	954
Foot-so-Port Shoe Company	1020
Geigy Pharmaceuticals	944
Gyne-Cytology Laboratory	937
Hotel Schroeder	954
House of Bidwell	1037
Hurley X-Ray Company	937
Keeley Institute	1022
Kennedy Mansfield	951
Knox Gelatine	950
Lakeside Laboratories	940, 951, 1014
Lederle Laboratories	953, 982, 983
Lilly, Eli and Company	964
Mallard, Incorporated	1020
Mallatt Pharmacy	951
Mather Pharmacy	951
Medical Protective Company	951
Merck, Sharp & Dohme	1032, 1033
Milwaukee Sanitarium Foundation, Inc.	1040
New York Polyclinic	1012
Orthopedic Appliance Company	1012
Parke, Davis and Company	934, 935
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	1031
Physicians and Hospitals Supply Co.	1011
Physicians Casualty Association	1011
Professional Business Service	1027
Quincy X-Ray & Radium Laboratories	1012
Rennebohm's	951
Rogers Memorial Sanitarium	1040
S. and L. Signal Company, Inc.	1037
Sacred Heart Sanitarium	959
St. Croixdale Sanitarium	937
Schering Corporation	opposite 942, 958, opposite 958, 962, 963
Schmid, Julius, Inc.	945
Searle, G. D. and Company	1005
Smith, Kline & French Laboratories	955
Shorewood Hospital Sanitarium	1013
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp.	956
Time Insurance Company	1025
Tutag, S. J., and Company	959
Upjohn	1035
Wallace Laboratories	961
Winthrop Laboratories	936, 960
Wisconsin Neurological Foundation	1018
Wyeth	947, 1006, 1021, 1036

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. E. Krcher Ashland	J. M. Jauquet 220 7th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe Rice Lake	F. H. Goetsch Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	Louis Milson 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	Kenneth Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	B. J. Haines Cadott	Second Tuesday
Clark	J. W. Koch Colby	T. N. Thompson Neillsville	
Columbia–Marquette–Adams	H. Y. Fredrick Box 253 Westfield	F. W. Gissal 132 Washington Ave. Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	W. S. Cusick Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. S. Gearhart 621 S. Park Madison	T. V. Geppert 113 N. Carroll Madison	Second Tuesday Sept. through June
Dodge	R. I. Bender 147 Front Beaver Dam	M. E. Royce Mayville	Last Thursday*
Douglas	Conrad Giesen 1514 Ogden Superior	J. McGinnis 2231 E. Fifth Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	R. A. Buckley 131 S. Barstow Eau Claire	G. E. Wahl 616 E. Grand Eau Claire	Last Monday
Fond du Lac	Josephine N. Pallin 73 W. 12th Fond du Lac	Howard Mauthe St. Agnes Hospital Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	Charles Shields Fennimore	H. W. Carey Lancaster	Last Thursday, March, June, Sept., and Nov.
Green	F. J. Bongiorno Albany	D. E. Mings Monroe Clinic Monroe	
Green Lake–Waushara	A. J. Wiesender Berlin	G. C. Stone 124 N. Wisconsin Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. Whitc Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	R. W. Quandt 1108 Main Jefferson	C. E. Quandt 804 Lincoln Ave. Jefferson	Third Thursday*

* Except June, July, and August

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. T. Garren 6124 Sheridan Rd. Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	A. A. Cook 1707 Main La Crosse	J. L. Jaeck 1836 S. Ave. La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	R. E. Hunter Argyle	Last Tuesday
Langlade	W. P. Curran Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah Merrill	
Manitowoc	H. J. Belson 904 S. Eighth Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	E. B. Brick 501½ Third Wausau	J. V. Flannery 404 Third Wausau	
Marinette–Florence	R. J. Rogers Oconto	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
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Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
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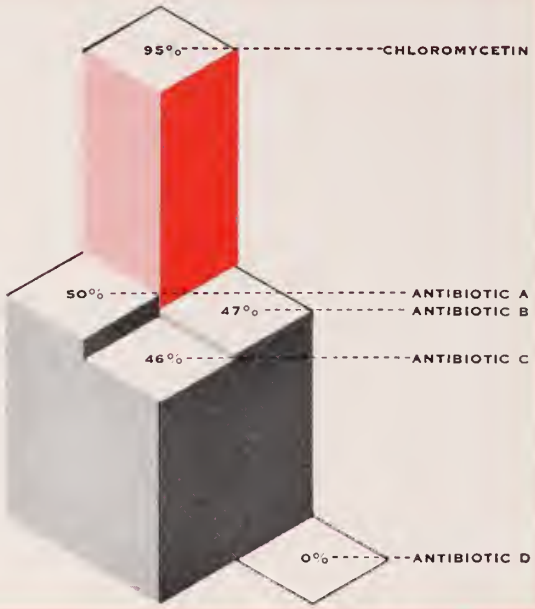

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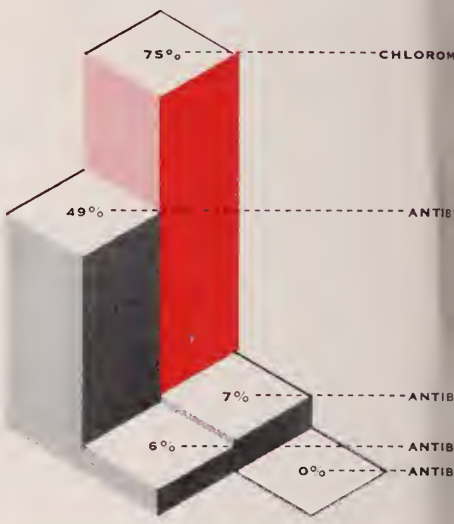

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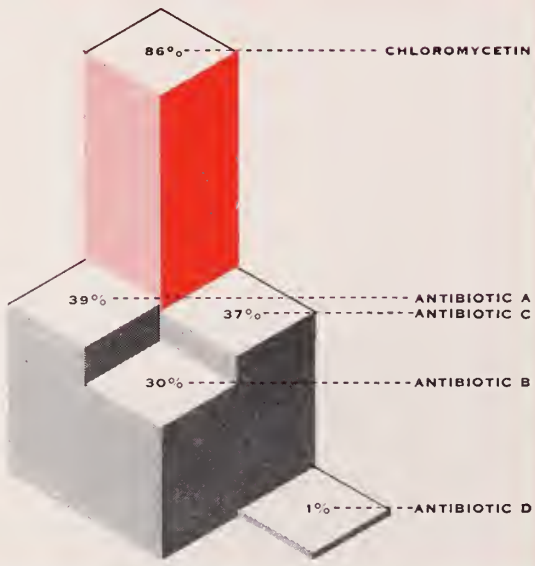

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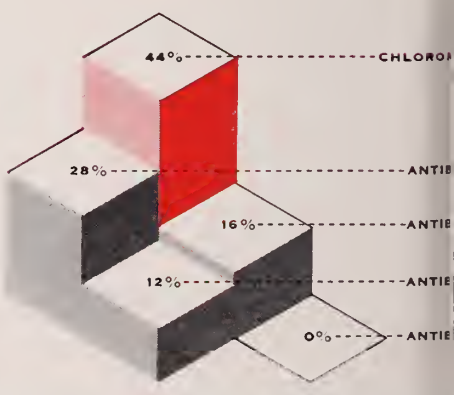

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
The Uses and Limitations of the Newer Drugs in the Treatment of Nervous Conditions, by Vernon Kinross-Wright, M. D.	1073
Gynecologic Cancer at University Hospitals, 1946–1955, by William Kiekhofer, M. D., and R. E. Campbell, M. D.	1079
Foreign Bodies in the Eye, by Everet H. Wood, M. D.	1086
Increasing the Safety of Obstetric Anesthesia, by Milton Davis, Jr., M. D.	1094
Clinicopathologic Conference	1097
Control of Diabetes	1104
Comments on Treatment	1105

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	Page
Gleanings from the Section on Medical History	1110
Society Proceedings	1125
News Items and Personals	1128
Third and Twelfth Districts News	1130
Society Records	1132
Facts about Wisconsin Physicians Service	1136
Obituaries	1137
Physicians' Exchange	1145
Index to Advertisers	1146
List of Officers and Scheduled Meetings of County Medical Societies	1149

EDITORIALS

The President's Page	1108
Functions of the State Board of Medical Examiners	1120

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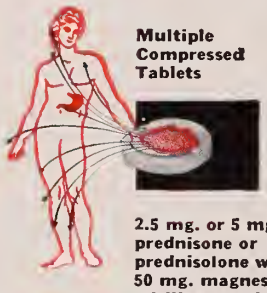
in inflammatory skin diseases

all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

ROUTINELY ACHIEVED WITH 'Co-Deltra'
(Buffered Prednisone)



Multiple Compressed Tablets

'Co-Hydeltra'
(Buffered Prednisolone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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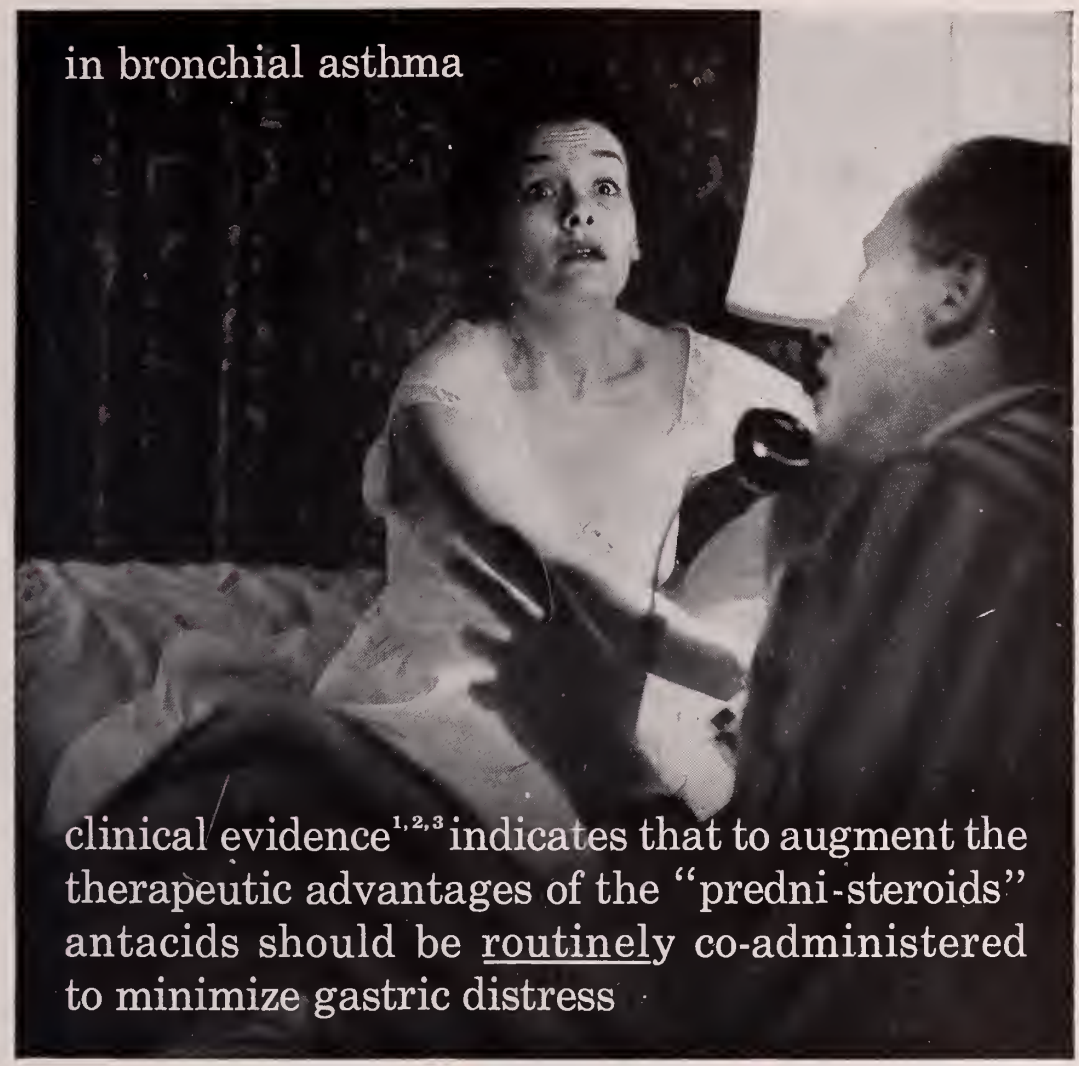

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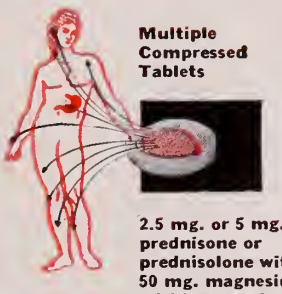

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'Co-Deltra'
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All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

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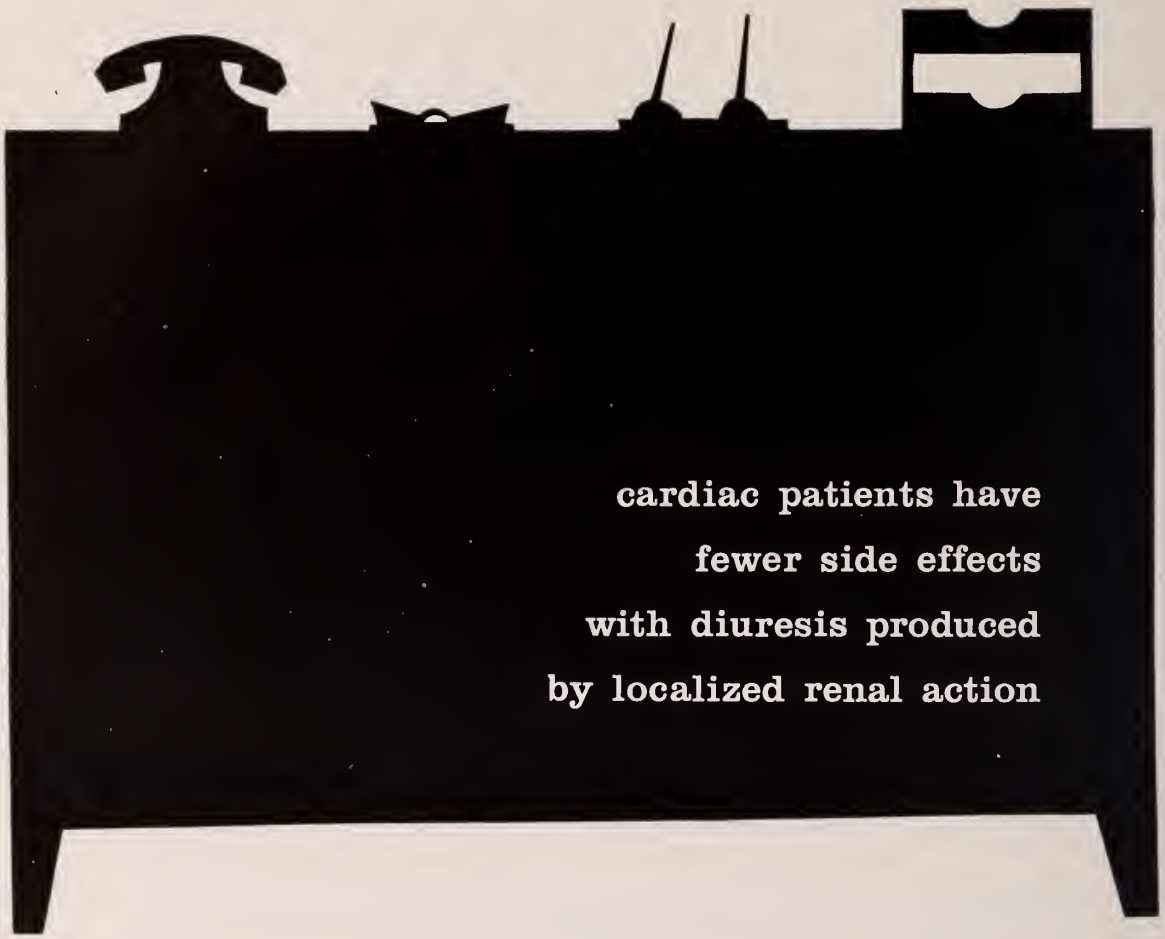

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1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

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1. Weiss, E., and English, O.S.: Psychosomatic Medicine. W. B. Saunders Co., Philadelphia, 1949, p. 358.
2. Lemere, F.: Northwest Med. *54*:1098 (Oct.) 1955.

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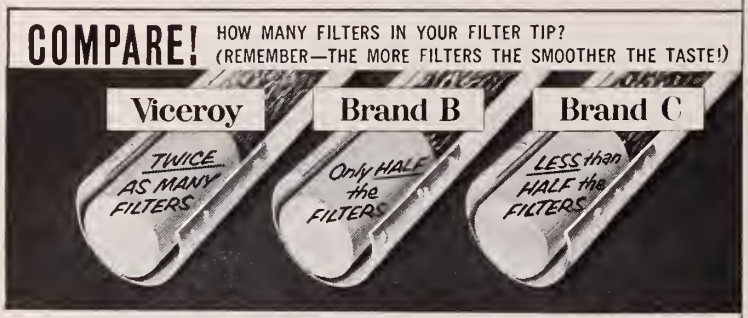

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Erythromycin in the treatment of osteomyelitis*

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

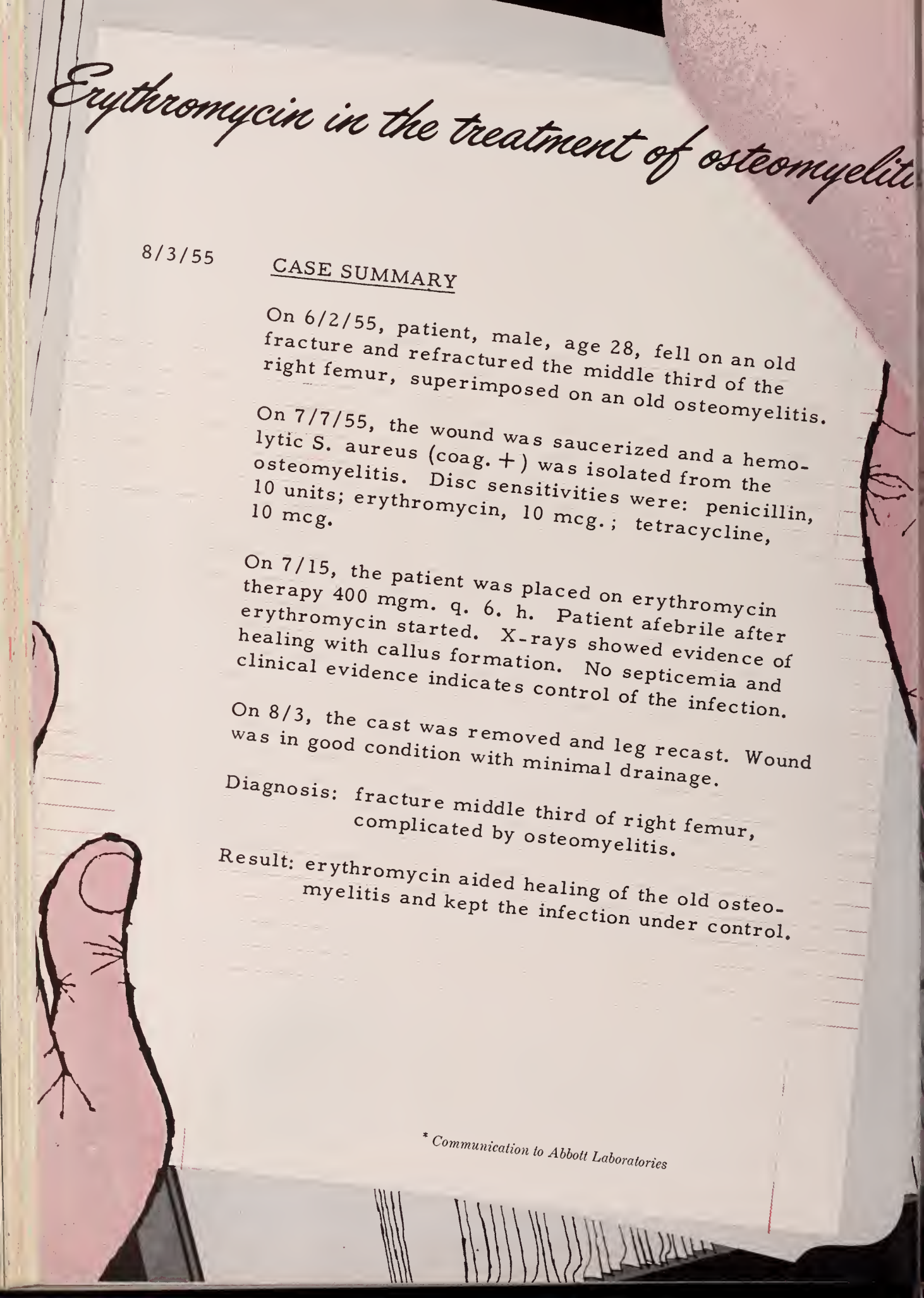
On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.



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effectiveness in allergic

and inflammatory dermatoses

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Meti-Derm cream 0.5%

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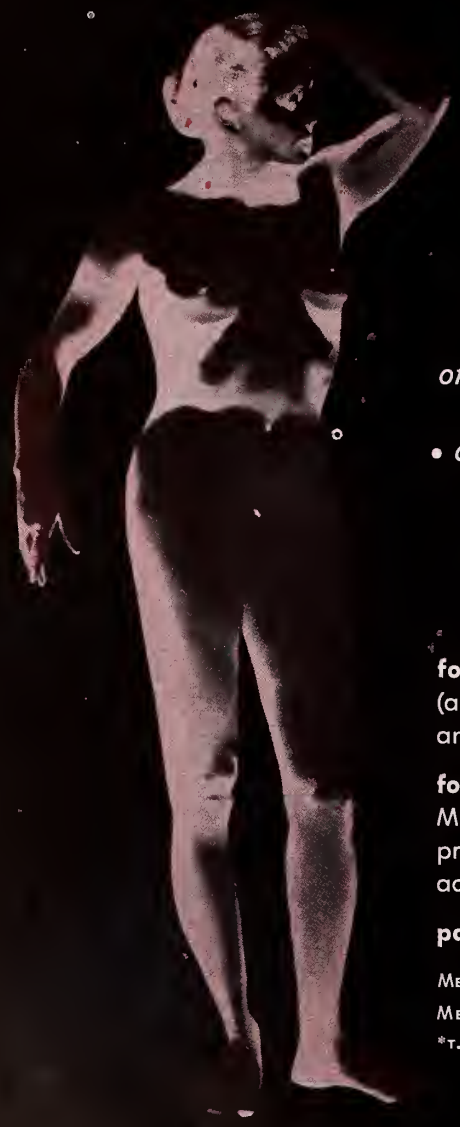

- *approximately*

twice the per milligram

anti-inflammatory activity

of topical hydrocortisone

- *cosmetically acceptable*
- *water-washable*

for effective local relief of allergic (atopic and contact) dermatoses, nonspecific anogenital pruritus.

formula: Each gram of water-washable METI-DERM Cream contains 5 mg. (0.5%) of prednisolone, free alcohol, in a cosmetically acceptable base.

packaging: METI-DERM Cream, 0.5%, 10 Gm. tub

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in allergic, inflammatory

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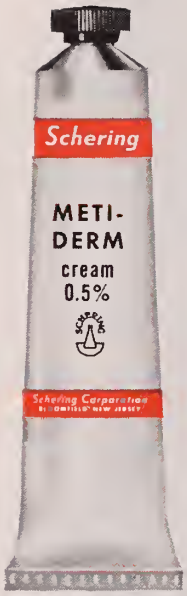

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The Uses and Limitations of The Newer Drugs in The Treatment of Nervous Conditions*

By VERNON KINROSS–WRIGHT, M. D.**

Houston, Tex.

YOU have no doubt been subjected to a barrage of literature from the drug houses about the new tranquilizing drugs in the past two years. I have, and it is very confusing. To complicate matters still further, the general public via the medium of the popular magazines has acquired a considerable knowledge about these compounds which puts a subtle pressure on the physician to use a drug with which he may not be entirely familiar.

The field of centrally acting drugs is a rapidly expanding one. For many years the physician has relied on barbiturates, chloral, and perhaps bromides for calming the nervous patient. And now what has he? Meprobamate, the rauwolfia derivatives, Frenquel, Thorazine, Sparine, etc. These are but the beginning, for all these substances can be simply modified in chemical structure to give new compounds, often with quite different properties and side effects.

What makes these drugs different? In short, they are sedatives without the depressant effects on the higher brain centers that barbiturates or alcohol have. They sedate but do not confuse, even in massive doses. Hence they do not impair judgment significantly, lead to antisocial behavior, or become addicting. Their site of action is subcortical, chiefly on the hypothalamus and the reticular system of the brain stem. They alter the functions of the autonomic centers of the brain which are intimately linked with emotional tone, and probably many kinds of mental illness. By way of the sympathetic and parasympathetic nervous systems they, in turn, influence the functions of viscera, blood vessels, and skin. Much of this activity is undesirable from the therapeutic point of view but is really an essential part of the drugs' actions. A similar thing is, of course, seen with the steroids. It is important to recognize this fact for it makes for confidence and understanding in using the drugs.

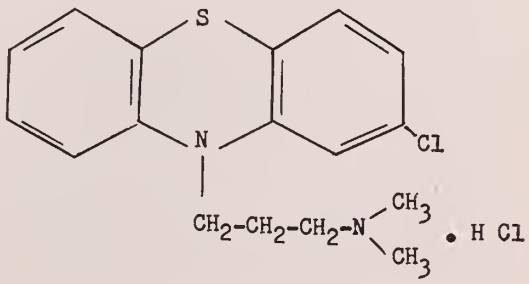
It will not be possible for me to discuss more than a few tranquilizers; and since I am sure most of you have used them, I will not try to cover the subject exhaustively.

CHLORPROMAZINE AND RESERPINE

Chlorpromazine and reserpine were the first, and are still the most important of these substances. Their chemical composition is quite dissimilar. Reserpine, one of the many alkaloids extracted from Rauwolfia, the snakeroot plant, has a complex structure resembling that of the ergots. Chlorpromazine is derived from phenothiazine, which some of you may know as a vermifuge.

The formula is shown to indicate the great activity of this basic structure. For example,

Chlorpromazine Hydrochloride = Thorazine



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removal of the chlorine atom gives Sparine, now coming on the market as a possible substitute for Thorazine. A slight change in the spatial arrangement of the Sparine molecule gives Phenergan, an antihistamine. If a nitrogen-containing ring is added to the side chain, there is produced a compound which causes a unique form of retinitis, and so on. Pacatal, a drug used extensively in Germany, is closely related.

Despite their wide chemical differences, reserpine and Thorazine are generally similar in their therapeutic effects; and I will consider them together. Reserpine is, of course, given in much smaller doses—about one fiftieth those of Thorazine. It has the disadvantage of having a slow onset of action, sometimes up to two or three days for full effect. Thorazine exerts its maximum effects within two hours. Both can be given parenterally with safety, though this is only necessary in very disturbed patients.

Both drugs have been used widely throughout medicine where sedation and tranquilization were required. Thorazine is also an effective antiemetic and reserpine a hypotensive agent. In our experience in Houston, we have found that the average physician uses them too often and in too small doses; this is particularly true of Thorazine. The safety factor of both these drugs is enormous. We have given over 4,000 mg. of Thorazine daily to a patient who was able to remain active and comfortable. A small child accidentally swallowed 200 mg. of reserpine and, apart from two days of good sound sleep, was none the worse. I do not of course advocate these doses as a matter of routine.

Common Indications for Chlorpromazine and Reserpine in Office Practice in Nonpsychotic Patients

States of Anxiety and Tension

Psychosomatic Syndromes in which tension is present. (Caution: Peptic ulcers sometimes aggravated by reserpine)

Insomnia—neither drug is really habit-forming

Anorexia due to emotional disturbance

In the hyperactive, "high-strung" child

Migraine

Convulsive Disorders—together with anticonvulsants

Mild Agitated Depression—avoid reserpine

Senile States with restlessness and mild confusion.

In my opinion, Thorazine is the drug of choice because of its more rapid action and because its common side effects are generally less bothersome to the patient. However, patients differ widely in their response to the two drugs, and a trial of both may be justified.

Neither drug is a cure-all for emotional disturbances. The relief is rarely more than symptomatic, and other measures must not be neglected. However, since many nervous patients have trouble with appetite and over-expenditure of energy, these drugs are often more effective then phenobarbital, which does not attack these symptoms. Most patients do not particularly enjoy taking these drugs. Only infrequently is there any sense of well-being or euphoria. Often the powerful autonomic effects cannot be easily tolerated by the patient, which prompts the physician to withdraw the drug. Do not be too hasty if you are achieving good therapeutic results. The vast majority of patients cease to experience these autonomic effects to an annoying extent after a few days because the autonomic centers readjust themselves. This is the reason why chlorpromazine is not an effective antihypertensive agent. Therapeutic results are usually apparent after a few days, though they may be delayed for several weeks. At any rate, an adequate trial should always be given.

On the whole, results in emotionally disturbed patients have been somewhat below initial expectations. In these people, environmental factors and personal and family problems which play so large a part in the development of illness cannot be reached by medication. It should not be forgotten, though, that relief of anxiety may put the patient in a much better position to solve these problems either by himself or with help.

There is one important property of these two drugs which has not received much attention—their ability to reduce drive or energy output, which is a specific cerebral effect that can be beautifully demonstrated in animals. Thus, the individual who is "overdoing it," the "wound-up" business or professional man, and the hyperactive child, who hardly regard themselves as "sick," do very well on one of these drugs. Incidentally, children tolerate them better than adults.

Indications for Chlorpromazine and Reserpine in Hospital Patients (Psychotic Patients)

(Involves use of large doses and requires experienced supervision)

Schizophrenia

Mania

Some Cases of Depression

Toxic and Organic Psychoses

Narcotic Withdrawal

Severe Neuroses

In the psychiatric hospital, treatment is given differently than in office practice. Massive doses, up to 2 or 3 thousand mg. of Thorazine and 10 to 15 mg. of reserpine, may be given daily for short or long periods. We have favored a short, intensive dosage regime for three weeks or so, followed by long-term maintenance on small doses after discharge. Thorazine is the drug of choice.

While opinion differs about the degree of recovery wrought with these agents, there is no doubt that the mental hospital ward has been revolutionized. Restraints are largely a thing of the past, and discharge rates are rising. Schizophrenia, our major mental illness problem, responds well—sometimes dramatically. Severe depressions have not been too amenable. The process of narcotic withdrawal is made quite painless with adequate dosage of Thorazine or reserpine. Toxic psychoses or deliria are frequently encountered in the home or in the general hospital and often present severe management problems. Thorazine given in 50 mg. to 100 mg. intramuscular doses every four to six hours is a highly effective treatment. Unlike other sedatives, it does not increase confusion. The typical patient with delirium calms within a few hours and is often clear within 24 hours. This holds true whether the toxic psychosis is due to fever, infection, trauma, or drugs. Remember that intramuscular injections of Thorazine are often painful (though I have never seen an abscess from this cause), and oral medication should be substituted when possible.

Side Effects of Chlorpromazine

The local and autonomic effects of chlorpromazine are mostly temporary and not dangerous.

Table 1 gives the common side effects of Thorazine and the approximate frequency of occurrence. After the first few days of treatment, even though the dose is increased, they lessen. In an occasional patient orthostatic hypotension may lead to fainting after the first dose or two. I make a practice of warning patients about these effects and couple the warning with the suggestion that they get out of bed or chairs with some caution. Burning of the throat and esophagus, which is noted on occasion, is due to the local irritant acidic nature of Thorazine. Actually, the drug has substantial local anesthetic properties, which you will note if you place a tablet on your tongue. The marked feeling of weakness and sluggishness some patients experience is due to inhibition of energy output and does not indicate toxicity.

TABLE 1—*Common Side Effects of Chlorpromazine*

Side Effect	Incidence	Side Effect	Incidence
Dry Mouth	90%	Constipation	40%
Nasal Congestion	80%	Increase of Appetite	80%
Facial Pallor	40%	Sedation	85%
Orthostatic Hypotension	80%	Lack of Drive	60%
Tachycardia	80%	Bizzare Dreams	25%
		Blurring of Vision	25%

TABLE 2—*More Serious Complications of Chlorpromazine Treatment*

Complication	Incidence	Complication	Incidence
Jaundice	0.1–1%	Photosensitivity	10%
Dermatitis	10%	Fever	5%

The complications listed in table 2 are more troublesome but much less common. They are sensitivity reactions based on an idiosyncratic response of the individual. They occur with *any* dosage, typically after 10 days' administration. They are rarely dangerous and may subside without cessation of medication. Unlike typical allergic reactions they usually do not recur when a second course of the drug is given. The percentages given for dermatitis and photosensitivity are probably too high for the northern part of the country since they were obtained in Texas, where the sun is a little fiercer. The dermatitis is characteristically a diffuse maculopapular eruption with moderate pruritus which responds to antihistamines, and subsides in a few days. I have seen 3 cases in which it became severe and was associated with angioneurotic edema and generalized urticaria. This necessitated the use of cortisone. Fever with chlorpro-

mazine most likely represents a transient disturbance of the hypothalamic temperature-regulating centers. It may spike to 104 degrees one or two days but is largely asymptomatic and requires no treatment. Jaundice has been the most discussed and feared complication of Thorazine treatment. I have seen only 3 cases in our own series of over 3,000 patients. Other sources indicate an incidence of up to 7%, but these have been smaller series and on close inspection include cases which are clearly not Thorazine jaundice.

The chief features of this condition are:

Onset 4–14 days. Duration 2 weeks–6 months.

Malaise, fever, icterus, anorexia, pruritus, hepatomegaly, acholic stools.

Constant findings are elevated serum bilirubin and alkaline phosphatase. Other liver function tests usually normal. Eosinophilia common.

Pathology shows intrahepatic biliary obstruction. Liver cells normal.

Treatment: Diet supportive.

Differential Diagnosis: Cholecystitis, carcinoma of pancreas, infectious hepatitis.

Same picture seen with testosterone, arsphenamine, sulfonamides, etc.

Note that an identical syndrome is seen with other drugs, in probably the same percentage of cases.

TABLE 3—*Chlorpromazine Jaundice*

(40-year-old female) (200 mg. daily for 13 days)

	Serum Bilirubin	Alkaline Phosphatase	Cephalin Flocculation	Thymol Turbidity	Prothrombin
1st day	5.4 mg. %	17.6	1+	?	100%
14 days	2.9	11	0	2	100%
28 days	0.6	4	1+	2	100%

Table 3 gives the results of liver function tests in one of our patients in whom jaundice lasted for nearly one month, though she had no symptoms other than icterus after the first few days. Liver biopsy on this woman showed normal liver cells, some lymphocytic infiltration, and plugs of bile in the canaliculi.

None of the foregoing complications bears any relation to the size of the dose. Paradoxically, the complications seem to occur less frequently with really high doses than with low ones.

Further Complications of Chlorpromazine

Parkinsonism — Faithfully mimics postencephalitic type, with high or sometimes with low chronic dosage. Always reversible. Treat by reducing dose.

Lactation—Always in female. Rarely associated with menstrual irregularities. Good for nursing mothers! Treat as above.

Depression—Rare but may be severe. Stop drug administration.

These three complications usually occur with high doses; *i.e.*, those over 200 mg. daily, although they have, once in a while, been associated with low doses. Parkinsonism develops over a period of several days and exhibits all the features of the true parkinsonian syndrome, including rigidity, festinating gait, salivation, and masklike faces. Once seen it can never be forgotten. It may take up to three weeks to subside after the Thorazine is reduced or stopped but leaves no aftereffects.

When we first encountered lactation in one of our female patients, we inevitably jumped to the wrong conclusion. Fortunately, the lady's protests were vindicated by the frog test. Minor degrees of engorgement of the breast and widening of the areola are probably not too uncommon with females on Thorazine. Frank lactation has been seen in a number of patients on large doses and may be linked with menstrual irregularities. The patients have generally been more intrigued than upset by it—at least once they have been reassured that they are not pregnant. This again illustrates the widespread action of chlorpromazine—this time on the hypophyseal–hypothalamic axis. A few cases of agranulocytosis have been reported in the literature, but this is extremely rare. Routine white blood cell counts are not necessary.

Side Effects of Reserpine

Reserpine side effects closely resemble those of its sister drug and will not be discussed in detail. Hypotension is rarely felt by the patient because of the slow onset of action of the drug. Nasal congestion, on the contrary, is more troublesome in most

TABLE 4—*The More Common Effects of Reserpine (Autonomic effects which are rarely troublesome)*

Side Effect	Incidence	Side Effect	Incidence
Nasal Congestion	90%	Edema of Ankles	15%
Dry Mouth	90%	Bradycardia	80%
Blurring of Vision	50%	Sleepiness	80%
Hypotension (Asymptomatic)	90%	Lack of Drive	60%

patients. Note that reserpine induces a slowing of the pulse whereas Thorazine usually increases it.

Less Common But More Serious Side Effects of Reserpine

Parkinsonism—Same as with chlorpromazine though more frequent.

Massive Facial Edema—Stop treatment. Use antihistamines or even corticosteroids.

Depression—Not infrequent and may progress to alarming degree. Stop administration of drug. Give analeptics (Ritalin or amphetamines). Watch for suicidal intent. Etiology unknown but more likely in predisposed persons and hypertensive patients.

Few individuals show the allergic types of response to reserpine, which is one of its major advantages over Thorazine. With large doses, occasionally a massive edema of the face and even trunk occurs; this requires active treatment. Ankle edema is common with reserpine and must be differentiated from renal or cardiac edema. The cause is not clearly established. Parkinsonism is encountered more frequently with reserpine than with Thorazine.

The final untoward effect of reserpine is mental depression, and this is being increasingly recognized. It can hardly be overstressed that this depression is potentially dangerous and may lead to suicidal attempts. It is likely that depression will occur only in a predisposed individual or in one who is already mildly depressed. This is often true of hypertensive patients in whom the depressive element may be masked by anxiety and tension. Any patient who develops depressive symptoms such as insomnia, anorexia, lack of interest, or crying spells while on reserpine (or any Rauwolfia compound) should be taken off medication and watched carefully. The following is an abbreviated history of a recent case:

> 37-year-old white housewife with 1-year history of tension, headaches, and insomnia. Blood pressure 180/88. Otherwise normal. Diagnosis: Anxiety state. Mild essential hypertension. Treatment: 0.5 mg. reserpine twice a day. One month later, blood pressure 140/74. Still tense and not sleeping. Slightly depressed. Reserpine increased to 0.5 mg. three times a day. Two weeks later, blood pressure 154/76. Poor appetite, anxious, and "draggy." Four days later, emergency house call.
>
> Patient prescribed for self: carbon monoxide inhalation (oven). Blood pressure 0/0. **Watch for Depression with Reserpine!**

MEPROBAMATE

Meprobamate = Miltown = Equanil
Related to Mephenesin

Sedative and muscle-relaxant properties
Centrally acting drug

Average dose 400 to 800 mg. three times a day by mouth

Another drug which has attained prominence recently is meprobamate, better known as Miltown or Equanil. Meprobamate is chemically and pharmacologically a cousin of mephenesin and acts quite dissimilarly to the two drugs we have been considering. While it is a centrally acting drug, it has no significant action on the brain autonomic centers. It relaxes muscle tone by an unexplained mechanism and also exerts a moderate sedative effect. As a consequence of this, its therapeutic potency is of a different order from the Rauwolfia alkaloids and Thorazine, and it has few side effects.

TABLE 5—*Meprobamate*

Useful for	Should Not be Used for	Side Effects
Tension states Muscle spasms Insomnia Mild excitement and agitation	Depressive states Severe psychoses	Sedation Occasional depression Occasional dermatitis

Table 5 lists the therapeutic applications, contraindications, and drawbacks. Where muscular tension is a prominent part of the clinical picture, meprobamate is useful. For severely agitated and anxious patients the author has found it of little use. It is often effective in relieving mild insomnia and has few aftereffects in the morning. It sometimes augments or produces depression.

NEW STIMULANTS

There are two other compounds which require brief mention here. Meratran and Ritalin are two new stimulants said to be superior to the amphetamines such as Benzedrine and Dexedrine. They interfere less with appetite and sleep than do the latter. They are also reported to cause less "jitteriness." In my experience results in most respects do not differ from those of dextroamphetamine though perhaps the new drugs are a little milder in action and therefore preferred by the patient. Given along with reserpine, they do seem to reduce the occurrence of depressive symptoms.

CONCLUSIONS

The tranquilizers are powerful agents. The high incidence of side effects requires more careful selection of patients than has been customary in the past. The therapeutic results will be greater, and unfortunate incidents will be avoided. I recall one patient who was given Thorazine to relax her while playing bridge. She subsequently spent three weeks in the hospital on cortisone for a severe dermatitis.

I think a close parallel may be drawn between the tranquilizers and the sulfonamides. When the sulfonamides first became available, use was rather indiscriminate and side effects were frequent. Now that indications are well established, the drugs occupy an honored, though smaller, niche in the physician's bag.

I believe any observant physician can use these new drugs without trepidation. One must be cautious, however, in giving them as a matter of routine to mildly neurotic patients. Often it is the color of the pill or the physician's bedside manner which produces beneficial results. I think it is worth while to undertake some individual research on this group by using a placebo for a short time. These often are surprisingly potent, and it is highly unlikely that they will produce jaundice or depression! If the placebo does not work, a tranquilizer can then be substituted. With marked nervous disorders where tranquilizers are clearly indicated, do not hesitate to use them. Here side effects are a justifiable price to pay for good results.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS MEETING

The American College of Obstetricians and Gynecologists will hold its meeting at the Palmer House, Chicago, on November 7–9.

Two hundred round tables and one hundred breakfast conferences have been scheduled; leaders of these discussions will be Fellows of the college and guest speakers with special knowledge on the particular subjects. Three panel discussions—dealing with anesthesia in obstetrics, problems concerned with adoption, and pathology of the breast—will be offered. Several formal papers will also be presented. An innovation will be the "consultation hours," to be held four times during the meeting. At each, a panel of three specialists will undertake to answer questions presented to them before the session or while it is in progress.

The annual banquet will be held on Thursday evening, November 8.

There is no registration fee for Fellows or Junior Fellows of the college. Candidates for fellowship or junior fellowship whose names have been published in the *ACOG Newsletter* will have a registration fee of $10. Residents in obstetrics and gynecology may register without charge upon identification. The fee for all other persons will be $20.

Three days of entertainment have been arranged for the wives of physicians attending the meeting.

Gynecologic Cancer at University Hospitals, 1946-1955

By WILLIAM KIEKHOFER, M. D., and R. E. CAMPBELL, M. D.

Madison

Introduction

THIS study is a review of all gynecologic cancer seen at the University of Wisconsin Hospitals during the last decade. It is not intended to be a research paper; we shall not seek to establish the superior merit of any particular therapeutic regimen, and we do not have any "new" findings or revolutionary success to report. We shall discuss incidence, therapy, and five-year survival statistics for our moderate-sized series of gynecological malignancies and compare these factors in the different types of cancer found.

Incidence

Cancer of the female genitalia ranks in incidence and mortality second only to cancer of the breast, and by only a few percentage points.[1] Like mammary neoplasm and unlike such other statistically significant tumors as lung or gastric cancer in the male, most gynecological cancer can be diagnosed relatively early and can give a comparatively satisfactory statistical result, as measured by five-year survival.

At University Hospitals malignancy has made up a steadily increasing proportion of the patient load on the gynecologic service. This is due in part to the decrease in the infectious diseases and in part to the greater number of gynecologic surgeons practicing in the state who "screen off" nonmalignant surgical problems, thus raising the percentage importance of cancer.

TABLE 1—*Carcinoma and Patient Load*

Year	Hospital Admissions, Thousands	Gynecologic Admissions	New Admissions, Cancer	Per Cent of Gynecologic Admissions, Cancer
1946	11.7	643	47	7.3
1947	12.0	619	71	11.5
1948	Not Available		52	
1949	11.5	540	72	13.3
1950	11.6	555	74	13.3
1951	12.1	543	54	9.9
1952	12.3	545	76	13.9
1953	12.7	439	79	18.0
1954	12.6	496	81	16.3
1955	13.2	541	64	11.8
			670	

Table 1 shows that total hospital admissions have increased moderately during the last 10 years while total gynecologic admissions have decreased somewhat, presumably also for the above reasons. New admissions for gynecologic cancer have increased slightly as compared to total admissions and have more than doubled as compared to the gynecologic patient load.

Material

During the period from Jan. 1, 1946, through Dec. 31, 1955, there were 670 patients with carcinoma of the female generative organs referred to the University Hospitals on the ward service. Fourteen of them had received adequate therapy at other institutions and were presumably sent here for consultation only. These 14 were, therefore, eliminated from our series and were the only ones so excluded.

The remaining 656 cases make up the series to be presented in this report. All patients had microscopically proved carcinoma, the vast majority of the slides being read or reviewed at this institution, either by the surgical pathology section or by the State Laboratory of Hygiene. Five-year survival statistics are now available for the 307 patients seen during the 1946 to 1950 period. In spite of strenuous efforts, we have lost contact with 9 of these patients, resulting in a follow-up of 97%. This figure is lower than that given in some recent reports, *e.g.*, McKelvey, Stenstrom, and Gillam,[2] but parallels or surpasses that given by many others, *e.g.*, Hahn,[3] Schmitz *et al.*[4] The 1951 to 1955 patients are presented merely to give an indication of the continuing cancer pattern at the University Hospitals. It should be noted that all patients reported in this series were ward cases while in the hospital. No private patients are included.

The 1953 recommendations of the American College of Surgeons Committee on Cancer[5] allow separation of cancer cases into two groups, those in which there has been

previous treatment and those in which there has not been. Of our 656 patients, 108 had some of their therapy at other hospitals. We have, however, decided to include these in our series for two reasons: (1) Almost all of the 108 patients were sent here for completion of their primary therapy within six weeks of its commencement and (2) Where inadequate therapy was administered elsewhere, we increased it to meet our standards.

Any case in which the patient died within five years after her first admission is herein considered a cancer death. In other words, we have made no effort to present a "corrected" mortality rate. It can be seen that these last two factors—inclusion of some patients partially but inadequately treated elsewhere and inclusion of deaths due to other causes—have lowered our survival statistics somewhat. The only survival rate which we have calculated is that at five years; no survival rates have been included for patients seen since 1950, and for long-term follow-up (over five years) our data are incomplete. Our figures would support the belief that about 75 to 80% of patients who survive 5 years are also alive at 10 years. Table 2 presents the data on our entire series.

TABLE 2—*Summary of Series*

Total Patients, 1946–1955	670
Consultation Only, Therapy Elsewhere	14
Total Cases Treated, 1946–1955	656
Cases Not Previously Treated	548
Cases Previously Treated	108
Total Cases Treated, 1946–1950	307
Lost to Follow-Up, 1946–1950	9
Follow-Up Rate	97%

The incidence of gynecologic cancer by years is indicated in table 3, with the slight discrepancies from table 1 being explained by the 14 cases omitted, as noted above. Compared with this incidence is that of cervical carcinoma seen during the same years. The relative importance of the latter is indicated by the fact that, year in and year out, two-thirds of all gynecologic cancer seen at the University Hospitals arises from the cervix. This corresponds closely to the experience of others.[6]

For purposes of this summary, our series of 656 cases has been divided into four major groups, comprising carcinomas arising in the vulva, the cervix, the body of the uterus, and the ovary. A fifth miscellaneous group consists of a few unusual malignancies. Table 4 shows the number in each group and re-emphasizes the importance of cervical cancer.

TABLE 4—*Carcinoma Types—1946–1955*

Organ	Number	Per Cent
Vulva	30	5
Cervix	436	66
Endometrium	126	19
Ovary	47	7
Miscellaneous	17	3
	656	100
Ratio of cervical to corporal cancer of the uterus:		3.5 to 1

In recent gynecologic literature much has been written about the ratio of cancer of the cervix to cancer of the corpus, quoted ratios ranging from 14 to 1 down to 1 to 1 or even lower.[7] Women of certain ethnic groups, particularly those practicing male circumcision; celibate women; and women of the higher economic levels have all been found to have low ratios. Our figure of 3.5 to 1, the cervical lesion being the more common, is considerably lower than the usual clinical figure, but corresponds quite closely to that reported from Milwaukee County Hospital.[8]

Plan of Management

The first step in the study of cancer patients is obtaining a thorough history and making a complete general physical examination, the pelvic findings being especially significant in estimating the clinical stage of the disease. Routine laboratory studies, including urinalysis, complete blood count, serology, and blood sugar and non-protein nitrogen determinations, are done. Many cancer patients seen at the University

TABLE 3—*Total and Cervical Carcinoma—Incidence*

Year	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955
Total Cancer	45	69	49	71	73	52	75	78	80	64
Cancer, Cervix	31	46	32	47	49	39	48	51	52	41
Cervix (Per Cent)	69	67	65	66	67	75	64	65	65	64

Hospitals have had their diagnosis already established by biopsy, in which case our clinical pathologist merely reviews the slides obtained from the referring physician. For others, definitive diagnosis may result from punch biopsy, circular biopsy, curettage, or even laparotomy. In no case is a positive Papanicolaou smear alone felt to be conclusive; histologic diagnosis is mandatory. In passing, it is worthy of note that some 90% of our patients are told their diagnosis. We feel that in this way we obtain much better cooperation and understanding. Emotionally disturbed and near-terminal patients make up the other 10%, and their condition is discussed with relatives.

Once the diagnosis of malignancy is established, certain special studies are made, partly to determine further the extent of disease and partly to serve as base lines for future evaluation. These studies include x-rays of the chest, spine, and pelvis, and kidney films with intravenous pyelography, proctoscopy, and cystoscopy. Barium enemas are often obtained as are any special studies suggested by the individual history and physical examination.

Depending on the particular type of therapy needed, the patient may require one, two, or even three hospitalizations lasting from three days to three weeks. We agree strongly with the University of Minnesota group that all radiation therapy should be conducted on an in-patient basis in order to control better the numerous side effects.[2] Special postradiation and postsurgical adjuncts include oil to radiated skin areas, frequent blood counts, transfusions and parenteral fluids, bland diets, bowel and bladder control as necessary, and diet supplementation with iron and multivitamins.

After completion of their primary therapy, our patients are followed for at least five years in our out-patient tumor clinic. For the first two years, during which approximately three-fourths of the recurrences may be expected to take place, the patients are seen at two-month intervals; thereafter, they are given return appointments every three months. The tumor clinic has recently begun sending brief summaries of these return visits to the referring physician. Recurrent disease is treated with such measures as palliative x-ray, radon seeding, reexcision, and general support. At the end of five years the patient is discharged from the tumor clinic to be followed by her referring physician. We attempt to see the patient annually for an additional five years.

Vulva

Five per cent or 30 of the genital malignancies reported in this series arose from the vulva. This is approximately the relative incidence noted in the world literature.[9, 10] Like other skin cancers, carcinoma of the vulva should be diagnosed easily at an early stage, thus achieving a high cure rate. For various reasons, however, the exact opposite is the case; and over half the patients present far-advanced tumors, usually including lymph node metastasis. A third of our patients, in fact, came to us in near-terminal condition. Of the 30 cases presently reported, 27 were squamous cell lesions and 3 were melanosarcomas.

Therapeutically, we believe in two-stage surgery—an extensive, complete vulvectomy followed in three weeks by a bilateral femoral node dissection. Only rarely do we feel that it is justified to remove nodes above the inguinal ligaments. We have sometimes given palliative x-ray therapy to the inguinal areas, but we have not been impressed with the merit of this. The primary tumor is, of course, never radiated. Table 5 summarizes our therapeutic efforts.

TABLE 5—*Vulvar Carcinoma—Therapy*

Vulvectomy and Node Dissection (two with x-ray)	13
Vulvectomy Only (palliative)	10
Vulvectomy and X-ray	4
X-ray Only	1
No Therapy Possible	2
	30

As may be guessed from the foregoing, our survival statistics for this disease are not encouraging. Only a third of our patients lived five years. The best survival statistics are those reported by Taussig,[10] and by McKelvey. Both of these authors achieved better than 50% five-year "cures." The University of Michigan group reports 43%.[6] Table 6, page 1082, indicates our survival experience, 36% at five years.

TABLE 6—*Incidence and Five-Year Survival—Vulvar Carcinoma*

Year	Total	Alive	Dead
1946	1	1	0
1947	3	1	2
1948	1	1	0
1949	5	1	4
1950	4	1	3
	14 Five-Year Total	5	9
Five-Year Survival: 35.7%			
1951	0		
1952	5		
1953	4		
1954	5		
1955	2		
	30 Ten-Year Total		

Cervix

As previously stated, about two-thirds of the female genital malignancies seen at the University Hospitals (436 cases from 1946 through 1955) arose from the cervix. This proportion holds true at other institutions[6] and serves to emphasize the grave importance of this disease.

Survival statistics given herein and by many other authors demonstrate the value of early diagnosis. In the case of the cervix, we employ the International clinical staging, which allows rather accurate statistical comparison. Briefly, stage 0 includes *in situ* lesions; stage I is cancer confined to the cervix; stage II represents tumor beyond the cervix but not out to the bony pelvic wall or down to the lower third of the vagina. Stage III cancer has reached one or both of these limits, while stage IV cases include those with bladder or rectal involvement or distant metastases.

Patients presenting themselves for therapy at the University Hospitals are not infrequently seen late in the course of their disease. In most reported series, the number of early lesions (stages I and II) is roughly equal to or somewhat greater than the number of late lesions (stages III and IV). Unfortunately, this is not true in our clinic; as can be seen from table 7, our series is deviated toward the "far-advanced" end of the scale, 40.3% of our patients being in stage III alone. For comparison, we have included the incidence of various stages from several other series. The distribution in the large League of Nations series quite closely parallels our distribution.

TABLE 7—*Cervical Cancer Incidence By Stages—Per Cent*

	University of Wisconsin	Minnesota[4]	California[4]	Philadelphia[3]	League of Nations[4]
Stage 0	5.3	----	----	----	----
Stage I	12.0	31.6	20.5	18.4	11.6
Stage II	27.1	36.6	35.8	14.2	27.8
Stage III	40.3	26.3	31.9	28.4	40.2
Stage IV	11.2	5.4	11.8	38.8	20.2
Unstaged	4.1	----	----	----	----

TABLE 8—*Comparison of Presenting Stage—1946–1947 vs. 1954–1955—Per Cent*

Stage	0	I	II	III	IV	Unstaged
Entire Series	5.3	12.0	27.1	40.3	11.2	4.1
1946–1947	2.6	5.2	23.0	49.8	16.8	2.6
1954–1955	7.6	15.2	26.1	39.2	6.5	5.4

TABLE 9—*Incidence and Five-Year Survival—Cervical Carcinoma*

Year	Total	Alive	Dead	Lost
1946	31	10	19	2
1947	46	13	32	1
1948	32	15	16	1
1949	47	24	21	2
1950	49	25	24	0
	205 Five-Year Total	87	112	6
Five-Year Survival: 42.4%				
1951	39			
1952	48			
1953	51			
1954	52			
1955	41			
	436 Ten-Year Total			

We were interested to see whether the great emphasis on early diagnosis during the last decade had had any clinical effect. Table 8 indicates that aside from an increase in stage 0 lesions detected by Papanicolaou screening, there has been no more than a suggestive change between the first years of the 10-year period and the last. The incidence of lesions presenting as stage III remains discouragingly high.

Our basic therapy for cervical cancer is external irradiation followed in six weeks by radon application. The dosages of both have been gradually increased over the years. The treatment of stage 0 lesions has been mainly a course of x-ray followed by a total hysterectomy; in recent years we have performed radical hysterectomies including regional

TABLE 10—*Cervical Carcinoma—Five-Year Survival, Over-all and By Stage—Per Cent*

	University of Wisconsin	Minnesota[4]	California[4]	Philadelphia[3]	League of Nations[4]	Michigan[6]
Over-all	42.4	53.6	39.9	26.3	26.7	42.2
Stage 0	100					
Stage I	75	80.2	65		56.1	
Stage II	61	54.1	48		37.3	
Stage III	31	29.5	24		22	
Stage IV	11	6	4.4		3.2	

node dissections on stage I lesions, but no pelvic exenterations have been attempted.

Table 9 shows the total cervical carcinoma patients seen during the 10 years since 1945 and the five-year survival rate for approximately the first half of them. Our over-all figure, 42.4%, compares favorably with results listed in the literature, particularly in view of the high proportion of advanced cases in our series. If 8 stage 0 lesions are omitted, the over-all five-year survival is 40.1%. Table 10 compares our five-year survival rates with those in several other large series.

Uterine Body (Endometrium)

Adenocarcinoma of the endometrium is, numerically, our second largest problem. During the decade covered by this report 126 patients were seen with this disease; this represents about the expected proportion of the total. We do not attempt any clinical staging of endometrial carcinoma, as we have not been impressed with the accuracy of such staging. Our therapy of choice in endometrial neoplasm consists of a course of x-radiation to the uterus and adnexa followed in six weeks by a panhysterectomy If, however, there is gross extension or metastasis or if the patient is not physically a candidate for major surgery, we follow the x-ray with intracavitary radon. Table 11 shows the total number of patients who received each regime; a slightly greater number received x-ray and radon, though no one was given this type of therapy by choice.

Table 12 reviews our total experience with uterine adenocarcinoma. Our over-all five-year arrest rate is 46.2%. This does not compare well with the rates in other series; most authors report survival rates of about 70%. Several of these series, however, deal with cases selected as to clinical stage. More nearly approximating our result is the five-year survival rate of 52.6% in the large Michigan series; at Milwaukee County Hospital it is 47%.[8]

TABLE 11—*Endometrial Carcinoma—Therapy*

X-ray and Surgery	49
X-ray and Radon	59
Incomplete Therapy	16
No Therapy	2
	126

TABLE 12—*Incidence and Five-Year Survival—Endometrial Carcinoma*

Year	Total	Alive	Dead	Lost
1946	10	5	4	1
1947	11	5	6	0
1948	14	9	5	0
1949	15	6	8	1
1950	15	5	9	1
	65 Five-Year Total	30	32	3
Five-Year Survival: 46.2%				
1951	7			
1952	13			
1953	13			
1954	16			
1955	12			
	126 Ten-Year Total			

Ovary

From a therapeutic aspect, carcinoma of the ovary is presently one of the most unsatisfactory of all malignant neoplasms. Those patients who do survive for five years are women in whom the lesion has been picked up fortuitously at an early stage or women who have relatively "benign" cancers. Over the decade covered by this report, we saw 47 ovarian cancers, most of them far advanced. A third of them had already been treated elsewhere.

Our basic therapy has been surgery, as extensive as possible, followed usually by a course of external irradiation, the latter being more hopeful than therapeutic and in the main palliative. Thirty-three of the patients were treated with surgery followed by x-ray, six by surgery alone.

TABLE 13—*Incidence and Five-Year Survival—Ovarian Carcinoma*

Year	Total	Alive	Dead
1946	3	1	2
1947	5	1	4
1948	1	1	0
1949	3	1	2
1950	2	1	1
	14 Five-Year Total	5	9
Five-Year Survival: 35.7%			
1951	5		
1952	6		
1953	9		
1954	5		
1955	8		
	47 Ten-Year Total		

TABLE 14—*Histologic Types of Ovarian Neoplasm*

Cystadenocarcinoma—Unspecified	20
Serous Cystadenocarcinoma	10
Pseudomucinous Cystadenocarcinoma	7
Granulosa Cell Carcinoma	4
Teratocarcinoma	2
Thecoma	1
Metastatic (Krukenberg)	1
Dysgerminoma	1
Undetermined	1
	47

Table 13 gives our ten-year experience and five-year survival rate with ovarian malignancy. Though based on too small a total number of patients to have any significance statistically, our 36% cure rate is about what might be anticipated for a series random as to histology. Table 14 lists the types of ovarian neoplasm which we have seen. Both the distribution by histologic type and the survival rate compare closely with those recently reported from the College of Medical Evangelists. The five-year survival rate in that series was 32%.[11]

Miscellaneous Malignant Tumors

For completeness, Table 15 includes some gynecological rarities treated at the University Hospitals. During the decade we have seen examples of most genital malignancies.

TABLE 15—*Rare Gynecologic Neoplasms—1946–1955*

Leiomyosarcoma—Uterus	6
Primary Vaginal Carcinoma	4
Adenosarcoma—Uterus	2
Vulvar Papilloma—Atypical Change	1
Adenocarcinoma of Fallopian Tube	1
Choriocarcinoma	2
Vulvar Myxofibrosarcoma	1
	17

Comment—Future Plans

In the future we plan to continue our tumor clinic approximately as presently organized. Therapeutically, we shall be interested to analyze our results using the one kilovolt x-ray machine which became available in 1952. We are commencing the multiple-packing technique for positioning intrauterine radon in the nonsurgical treatment of endometrial carcinoma. A few patients with ovarian malignancy complicated by ascites have been treated with radioactive colloidal gold. There is some reason to believe that there will be an increase in radical surgery for the stage I and II lesions, especially in the younger age group and for radioresistant tumors. Lastly, we shall continue to participate in the hospital cancer research program, giving clinical evaluation to laboratory-produced "cancerocidal" agents.

Summary

1. A ten-year series of 656 gynecological carcinomas has been presented; 307 of these were eligible for five-year follow-up, and the follow-up rate was 97%.
2. Five-year survival rates for the period 1946 to 1950 were:

Cancer of the Vulva	36%
Cancer of the Uterine Cervix	42%
Cancer of the Uterine Corpus	46%
Cancer of the Ovary	36%

3. Better therapeutic results can be achieved chiefly through earlier diagnosis.

(W. K.) 1300 University Avenue.

The authors wish to thank especially the many physicians who took time to fill out the questionnaires upon which this survey is based.

REFERENCES

1. Metropolitan Life Insurance Company Statistical Bulletin.
2. McKelvey, J. L., Stenstrom, K. W., and Gillam, J. S.: Results of experimental therapy of carcinoma of cervix, Am. J. Obst. & Gynec. 58:896–907 (Nov.) 1949.
3. Hahn, G. A.: Carcinoma of cervix uteri treated at American Oncologic Hospital, 1929 to 1949, Am. J. Obst. & Gynec. 69:48–58 (Jan.) 1955.
4. Schmitz, H. E., Geiger, C. J., Smith, C. J., and Blichert, P. A.: Carcinoma of cervix; failure of haphazard treatment, Obst. & Gynec. 4:75–81 (July) 1954.

5. American College of Surgeons Manual for Cancer Programs, 1953.
6. Latourette, H. B., Lampe, I., and Hodges, F. J.: Organized clinical investigation of cancer—ninth annual report, Univ. of Mich. Med. Bull. 20:283–302 (Nov.) 1954.
7. Strand, C. M., and Wheelock, M. C.: Ratio of cervical carcinoma to corpus carcinoma, Obst. & Gynec. 4:380–382 (Oct.) 1954.
8. Cron, R. S., Hofmeister, F. J., Brown, R. C., and Bartzen, P.: Endometrial carcinoma, Am. J. Obst. & Gynec. 70:548–553 (Sept.) 1955.
9. Te Linde, R. W.: Operative Gynecology, ed. 2, Philadelphia, J. B. Lippincott Company, 1953, p. 742.
10. Taussig, F. J.: Cancer of vulva; analysis of 155 cases (1911–1940), Am. J. Obst. & Gynec. 40:764–779 (Nov.) 1940.
11. Gardiner, G. A., and Slate, J.: Malignant tumors of ovary, Am. J. Obst. & Gynec. 70:554–562 (Sept.) 1955.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1956, the March of Medicine began its eleventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	12:15 p.m.
WHSA	Brule	Friday	10:30 a.m
WHKW	Chilton	Friday	10:30 a.m
WCHF	Chippewa Falls	Saturday	9:45 a.m.
WHWC	Colfax	Friday	10:30 a.m
WHAD	Delafield	Friday	10:30 a.m
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Friday	10:30 a.m
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Friday	10:30 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	5:00 p.m
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	1:00 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	9:05 a.m.
WHRM	Rib Mountain	Friday	10:30 a.m
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Wednesday	1:45 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WLBL	Stevens Point	Friday	10:30 a.m
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	11:00 a.m.
WBKV	West Bend	Saturday	11:15 a.m.
WHLA	West Salem	Friday	10:30 a.m

Foreign Bodies in The Eye

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Madison

MANAGEMENT of the patient who presents himself in the doctor's office with the complaint that he has "something in his eye" is a problem that confronts general practitioners frequently and ophthalmologists not only daily, but often several times in the same day. Some of these patients are easily treated, and others tax the judgment of the examining physician as heavily as any medical problem can. This presentation is offered as a guide to the recognition, diagnosis, and treatment of patients actually having foreign particles in the eye.

General Considerations

Since the eye is an organ of the body exposed to the surrounding environment of the individual practically 100% of the time, except in instances when specific protective devices are used, it is a vulnerable structure, and no part of it is exempt from the hazard of injury by flying debris. Particles may lodge in the lower conjunctival sac, under the upper lid, deep in the upper fornix, in the cornea, in the sclera, and in any of the structures within the fibrous coat. Occasionally a particle may completely traverse the globe and lodge in the orbit; however, in peacetime civilian practice such an occurrence is rare. The particles may be of many varieties, ranging from pieces of dust, vegetable matter, eyelashes, and seeds, to particles of metal, cement, or glass, to mention only a few of the possibilities. The particles may be minute pinpoint specks or pieces of considerable bulk. The greater the size, the more the potential damage to the eye.

Practically no occupation, or lack of an occupation, renders an individual free from the possibility of getting a foreign particle in his eye. Superficial conjunctival and corneal foreign bodies are most frequently lodged in the eye as a result of dust from city streets blown about by gusty winds. Other episodes leading to superficial specks in the anterior structures are the obnoxious tricks of some children, throwing sand at each other; the shattering of glass in auto accidents; the flying of bits of burdock burrs[1] encountered in the woods on hunting trips; and the injudicious grinder, working on a whirling stone without protective goggles. Many other factors resulting in superficial ocular foreign bodies exist, but those mentioned are frequent.

Foreign bodies penetrating the fibrous coat and lodging in the interior of the eye are fortunately much less frequent than the superficial ones.[2] The most common forerunner of such a catastrophe is striking some steel object against another similar object, such as a boy's striking the frame of his bicycle with a hammer while fixing it or a laborer's striking a cold chisel with a hand sledge hammer. The particles resulting are usually magnetic. Nonmagnetic particles such as BB shot or buckshot (although these are frequently magnetic now), pieces of brass or lead, and glass from windshields or spectacles may penetrate the eye. "Do It Yourself" projects are especially likely to give rise to intraocular foreign bodies if steel-on-steel hammering is involved, since the worker is often unskilled in using his tools.

Most destructive of all intraocular foreign bodies are those encountered as a result of war.[2, 3] The particles are frequently large, fly at high speeds, and may consist of any conceivable type of material. The kind of wound resulting occurs occasionally in peacetime, as in an explosion or a severe tornado.

History

Most important in the management of patients complaining of "something in the eye" is the diagnosis of the exact nature of the condition. As in all medical practice the first step is obtaining an accurate history. One must ascertain how, when, and where the patient sustained his injury; and as nearly as possible the recorded statement should be in the patient's own words. Such statements as "While working I got something in my eye," are totally inadequate. The statement must be like the following one, "While I was grinding a cam yesterday at

about 3:00 p.m., in the Ford garage, a piece of steel flew in my right eye." If the patient does not offer such information, it should be gained by asking the necessary questions. Such accurate statements are necessary for the proper recording of the accident, and are likewise helpful in making the diagnosis. For example, the foregoing statement suggests a corneal foreign body, very likely deeply embedded and possibly surrounded by a rust ring. A statement such as the next one would suggest an intraocular foreign body: "While I was making a hole in a cement floor with a cold chisel, at the new building on Court Street, a piece of the chisel broke off and hit me in the left eye. It was about one-half hour ago." If the history indicates that the wind blew a piece of dust in the eye, a simple conjunctival or superficial corneal particle is suggested. Once the nature of the accident is known, it is important to inquire into previous accidents to the same eye, the wearing of glasses, and any previous eye disease. The general health of the patient is likewise an important thing to know about. Such histories are often more accurate at the first visit than at a later visit.

Once the general facts are established, the symptoms produced may be of great help in localizing the suspected foreign particle. A speck lodged under the upper lid produces a continuous scratching sensation, particularly when the eye is moved about; profuse watering; "bloodshot" eyes; and little disturbance of vision.

A particle embedded in the cornea produces similar sensations but usually feels worse when the eye is closed, and the eye is frequently quite sensitive to light.

Intraocular foreign bodies may produce a wide variety of symptoms ranging from none to complete loss of vision. If the symptoms are severe, one is more likely to suspect an intraocular foreign body; but all too frequently absence of symptoms and no loss of vision at first examination may be the case, so if the history has been adequate, one will not overlook the possibility of intraocular foreign bodies. The penetrating pieces of steel, etc., travel at such a high velocity and are often so small that at first they give rise to little damage and, hence, few symptoms. The late results of such a situation may be completely disastrous.

Examination

When the history is complete, the first step in examination should always be the estimation of the patient's vision. It is wise to determine the vision of the injured eye first because often the recorded vision will be more accurate if taken this way. It is mainly for the doctor's protection that vision be ascertained before any other examination or treatment is done for this avoids any claim on the part of the patient that the treatment caused loss of vision.

The second step in diagnosis is the inspection of the injured eye. For any proper examination of an injured eye two things are of major importance—adequate lighting and some magnification.[4] A good concentrated light may easily be directed on the eye in several ways. The simplest is the use of a small magnifying lens in conjunction with a good source of light near the eye. One may use any of several commercial examining lamps or even a good pocket flashlight that produces a bright spot of light. The beam of light is most useful when directed obliquely toward the eye, using the iris as a mirror and reflecting the light back out through the cornea.

Magnification of sufficient strength to locate most corneal and conjunctival foreign particles can be obtained by the ordinary binocular loupe. Several varieties are available and are inexpensive.

On inspection, the eye with the superficial conjunctival foreign body is usually mildly congested, is watering profusely, and is not particularly sensitive to light; however, if the particle is embedded in the cornea, the congestion is usually more marked, has a purplish tinge, and is more evident around the limbus than in the periphery of the conjunctiva. In these cases, too, the eye waters profusely and is often sensitive to light. Occasionally there will be a rust ring surrounding the foreign particle. If this is the case, the patient should be referred to an ophthalmologist for treatment. Corneal particles show as small black spots on the cornea when oblique illumination is used. It may be necessary to have the patient gaze in all directions to locate the particle. It is always good policy to examine the cornea first, even though the patient states that the foreign body is on the upper lid, because the sensa-

tion is quite the same. Should no foreign body be found on first examination, several possibilities exist. First, there may be one on the upper lid; the next step is to evert the lid. Particles have a way of hiding under the small ledge along the lid margin, and it is well to search this area carefully.[5] A speck may also be found under the everted tarsus, so double eversion is sometimes necessary to find it. Occasionally a particle is so small that it escapes notice even with the loupe, and the slit lamp and corneal microscope must be used to locate it. Estimation of the depth of penetration of a corneal foreign body is essential for its proper removal, so careful inspection of the site must be done. The loupe will often suffice to show a superficial particle, but the slit lamp is important if the foreign body does not seem to be on the surface; therefore, the patient should be referred to an ophthalmologist.

If the history suggests a penetrating particle, the diagnosis becomes more difficult, particularly if the patient does not present himself for examination until 12 to 24 hours after the accident occurred. One must search thoroughly over the entire exposed surface of the eye, for frequently after 24 hours the wound of entrance, should it be through the sclera, will be entirely healed and show almost nothing to suggest injury.[2] Ophthalmoscopic examination with the pupil dilated may reveal the presence of an intraocular particle when no wound of entrance can be found. Other times the perforation of the eyeball is quite obvious because the cornea has been penetrated, the pupil may be distorted, and iris tissue may even be prolapsed through the wound. If such a wound occurs, the eye may show blood in the anterior chamber and vitreous, which blocks the view with the ophthalmoscope. Such cases, of course, should be treated by the ophthalmologist.

X-rays

Whenever an intraocular foreign body is suspected, x-ray is imperative,[2, 3, 4, 6, 7] as is a complete ophthalmoscopic survey of the eye. There are times when a particle is so small it does not show on x-ray, but can be seen with the ophthalmoscope. When the presence of an intraocular foreign body is definitely determined, then the patient should be in the hands of a competent ophthalmic surgeon for its further care. Accurate localization of the position of the piece within the eye is essential in order to choose the proper method of approach for its removal.[8, 9] It is likewise essential to know the character of the material, that is, whether or not it is magnetic. If it is not, it is questionable whether an attempt should be made to remove it. Small metal fragments of lead, for example, may be left alone, while such things as copper or wood should be removed if possible. Such procedures, however, belong in the ophthalmologist's sphere of activities and should not be attempted by the general practitioner.

One final word of caution should be part of the discussion of diagnosis, and that is that one should never be satisfied with finding *a* foreign body; there may be more than one, and both eyes may be affected. Examine thoroughly.[2, 3, 8]

Treatment

Treatment of foreign bodies in the eye can be summarized in one brief sentence. Remove them. Like the diagnosis, sometimes it is simple to remove a speck from the eye and at other times most difficult.

The great majority of foreign particles that lodge on the conjunctiva under the upper lid may be removed by simple eversion of the lid and brushing the particle off with a wet cotton applicator. Usually no after-treatment of any kind is necessary, though it may be a wise procedure to apply an ointment containing a broad-spectrum antibiotic such as Aureomycin or erythromycin as a prophylactic measure to prevent subsequent infection. Even if a particle is embedded in the conjunctiva, its removal with a small, sharp instrument is not usually difficult and may be easily performed by any physician.

If the foreign particle is a burdock burr, the task becomes more difficult.[1] These fine barbs are difficult to see, are often hidden by mucus surrounding them, and always require magnification for removal. The area around the barb shows marked localized congestion, in the center of which the fine end of the barb can be seen protruding above the surface. The best method of removal in my hands has been the use of a good epilation forceps. One must be sure that as much as possible of the mucus is cleared away; then grasp the barb with the forceps and extract it. These barbs are quite strong and do not

tend to break when handled in this manner. When such a particle has been in the conjunctiva, the cornea is invariably scratched in multiple crisscrossed lines, so it is essential to protect this eye from infection. Dilation of the pupil is not necessary; but antibiotics should be applied for 24 to 48 hours after the removal, and the patient should be seen the following day to make sure the eye has healed satisfactorily.

Superficial corneal foreign bodies create a somewhat more difficult problem; however, any physician should be able to handle them without fear of damaging the eye. Since the cornea is exquisitely sensitive, it is necessary to anesthetize it before attempting to remove a particle from its surface. Any of several instillation anesthetics can be used—Pantocain, 0.5%; cocaine, 4%; Butyn, 2%; or Holocaine, 1%. One drop of any of these produces sufficient anesthesia in 30 seconds to remove most corneal foreign bodies. I believe an attempt should be made, using a loupe for better visualization, to brush off the foreign bodies with a cotton applicator soaked in water or normal saline. If two or three light swipes across the area fail to release it, then a resort to some blunt instrument to try to pick the foreign body off the cornea is the next step. If the blunt instrument fails after two or three tries from as many different approaches, then I believe the patient should be referred to the ophthalmologist for further attempts, since it probably will be necessary to use a sharp instrument[6] and one inexperienced in the use of such instruments on the eye could cause serious damage. However, if the foreign body is successfully removed either by the applicator or blunt spud, then antibiotics should be applied; in this case the eye should be bandaged since at the time of removal of the foreign body the eye is still anesthetized and could harbor additional particles without the patient's being aware of their entry. The patient should be seen on the following day for a check on the cornea and also for recheck of vision.

Should the foreign particle be from a grinding mishap, it is quite likely to be deeply embedded in the cornea and will frequently be surrounded by a ring of rust infiltrating in the tissues around the foreign particle. These cases should all be referred to the ophthalmologist because removal of the rust ring is a most essential part of the care of these eyes.[2, 4] Failure to remove the rust is just as damaging to the eye as failure to remove the particle itself. Many ways of clearing the rust are used; and each ophthalmologist has his own favorite method, but all accomplish the same purpose. The aftercare of patients having foreign bodies with rust rings is more complicated. These eyes must be put at rest, preferably with atropine, 1%, and antibiotics applied. Many physicians also use an anesthetic and antiseptic as well. Bandage is important, usually with mild pressure. The patient should always be seen the following day and as many times subsequent to that as the case may warrant. A final check should be made on the patient's vision before he is discharged.

The management of intraocular foreign bodies is without question a task for the ophthalmologist. Since this paper is primarily for the general practitioner, I shall make no attempt to describe the various surgical procedures designed to remove these dangerous intruders. Suffice it to say that early recognition and x-ray localization are two of the most important factors and are frequently within the realm of the general practitioner. Early removal is important also but not nearly so important as accurate localization.[8, 9] If there is any doubt about the first attempt at localization, one should not hesitate to repeat the procedure two or three times if necessary to insure accuracy. All patients with intraocular foreign bodies belong in the hospital. The choice of approach is determined by the position of the foreign body; and, if it is a magnetic piece, the magnet should be applied as near to the particle as possible.[8] If the fragment is nonmagnetic, there is doubt whether or not an attempt should be made to remove it. The character of the material, its position, and the ease of approach should all be considered in making the decision. One cannot generalize on the aftercare in cases of intraocular foreign body removal. Each case is an entity and has to be cared for as the situation demands.

Complications

Complications of foreign bodies in the eye can result, in the most serious cases, in loss of both eyes. Conjunctival foreign bodies seldom lead to any complications. Superficial corneal foreign bodies rarely lead to any

complications if treated properly. The most feared complication is an ulcer of the cornea harboring the *Pseudomonas aeruginosa (Bacillus pyocyaneus)*. This bacillus produces a fulminating infection which is extremely resistant to treatment. Polymyxin is about the only substance that will inhibit its growth. Since fluorescein solution often is contaminated with *B. pyocyaneus*, it is well to take every precaution to keep staining solutions sterile.[10] It is actually far better to use sterile strips of filter paper soaked in 20% fluorescein, dried and autoclaved, than to use solutions for staining the cornea for diagnostic purposes.[11]

Complications of intraocular foreign bodies are multiple, depending on many factors.[3] A detailed discussion is beyond the scope of this paper. One or two of the most dreaded can be mentioned. Retinal detachment is an all too frequent complication of foreign bodies removed through the sclera and should be watched for in the early postoperative period and at regular intervals for at least six months. When the foreign body has traversed the ciliary region, particularly if there has been prolapse of uveal tissue, the possibility of sympathetic ophthalmia is an ever-present threat. Should this develop and go unrecognized, both eyes may be lost. Such eyes are really never completely free from the danger of sympathetic ophthalmia. Cases have been reported as long as 36 years after the original injury.[2, 3]

Summary

An attempt has been made to discuss briefly the common locations of foreign bodies in the eye, both superficial and intraocular. Some of the more common ways of sustaining such particles, such as from wind on the streets, grinding wheels, hammering with steel on steel, and fast-flying particles from explosions, are discussed.

The salient points of diagnosis are discussed, placing particular emphasis on the detailed history of the accident and the accurate localization of intraocular foreign bodies.

Treatment of foreign bodies in the eye is described with the general practitioner particularly in mind, and an attempt is made to indicate where the general practitioner should stop and refer his case to the ophthalmologist.

A brief discussion of the treatment of foreign bodies in the various parts of the eye has been included, with no attempt made to go deeply into the various methods for removing intraocular foreign bodies since this is strictly an ophthalmological problem.

Conclusions

1. Foreign body in the eye is one of the most frequent injuries seen by physicians and can happen to people in any walk of life.

2. Obtaining a careful and detailed history is of utmost importance in diagnosing the location of foreign bodies in the eye.

3. Estimation of visual acuity should be the first step in the examination of injured eyes.

4. Superficial conjunctival and superficial corneal foreign bodies can be safely and satisfactorily managed by the general practitioner.

5. Deeply embedded corneal foreign bodies and those with rust rings should be handled by the ophthalmologist.

6. Intraocular foreign bodies are hospital cases and should always be an ophthalmologist's problem.

7. Accurate localization is the most important part of the diagnosis when an intraocular foreign body is encountered.

8. Proper postoperative treatment is essential in all cases of foreign body in the eye to prevent infection.

9. Careful vigilance after surgical removal of intraocular foreign bodies, particularly those involving the ciliary region, must be kept up for many years in order to recognize sympathetic ophthalmia, should it occur, in the early stage.

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30 South Henry Street.

I wish to acknowledge the inspiration and encouragement of Dr. Peter A. Duehr in the preparation and compilation of this paper.

REFERENCES

1. Havener, W. H., Falls, H., and McReynolds, W.: Burdock bur ophthalmia, A.M.A. Arch. Ophth. 53:260–263 (Feb.) 1955.

2. Duke-Elder, S.: Text-book of Ophthalmology, vol. 6, St. Louis, C. V. Mosby Company, 1954, p. 6152.

3. Wilder, H. C.: Intraocular foreign bodies in soldiers, Tr. Am. Acad. Ophth. 51:585–593 (July–Aug.) 1947.

4. Callahan, A.: Foreign bodies of eye, J.A.M.A. 142: 249–256 (Jan. 28) 1950.
5. McCannel, M. A.: Office management of ocular injuries, Postgrad. Med. 18:542–552 (Dec.) 1955.
6. Fox, S. A.: Removal of deeply embedded foreign bodies from cornea, Arch. Ophth. 37:189–193 (Feb.) 1947.
7. Roper-Hall, M. J.: Review of 555 cases of intra-ocular foreign body with special reference to prognosis, Brit. J. Ophth. 38:65–99 (Feb.) 1954.
8. Gundersen, T.. Surgery of intraocular foreign bodies, Tr. Am. Acad. Ophth. 51:604–613 (July–Aug.) 1947.
9. Droegemueller, W. H.: X-ray localization of intra-ocular foreign bodies, Tr. Am. Acad. Ophth. 51: 601–603 (July–Aug.) 1947.
10. Murphy, J. T., Allen, H. F., and Mangiaracine, Anita B.: Preparation, sterilization, and preservation of ophthalmic solutions; experimental studies and a practical method, A.M.A. Arch. Ophth. 53:63–78 (Jan.) 1955.
11. Kimura, S. J.: Fluorescein paper; simple means of insuring use of sterile fluorescein, Am J. Ophth. 34: 446–447 (March) 1951.

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Increasing the Safety of Obstetric Anesthesia

By MILTON DAVIS, JR., M. D.

Madison

SIGNIFICANT progress has been made in Wisconsin during the last 15 years in decreasing maternal and fetal mortality. In 1945 the maternal mortality was 1.3 per 1,000 live births. In 1955 it was 0.24. This has been accomplished by careful study of deaths and education of the medical profession concerning safe obstetric care.

Only since the major obstetric dangers have been attacked and in considerable measure eradicated has it become apparent that anesthesia in obstetrics is hazardous. This, of course, anesthetists have known for many years; but it remained for the Bureau of Maternal and Child Health, in cooperation with the Study Committee of the Division on Maternal and Child Welfare of the State Medical Society, to do something about it. It is at their request that this article is prepared.

The two types of deaths which focused attention on the problem were those due to:

(1) Inhalation of gastric contents
(2) Complete respiratory paralysis attending caudal block.

Both of these complications may be prevented or may be successfully treated once they have occurred. Therefore, it shall be the purpose of this presentation to call attention to some of the more dangerous practices in obstetric anesthesia and to direct attention to prevention of complications and treatment should they occur.

The Unconscious State

Regardless of which anesthetic drugs are used to make a woman in labor unconscious, the mere fact that she is unconscious places her in jeopardy. Most women in labor have food in their stomachs. If labor begins before the stomach is empty from a previous meal, very frequently gastric emptying ceases. If labor begins while the stomach is empty, many women will have a quick meal before leaving for the hospital, as a means of fortification. After all, it is called "labor," and there is work to be done! Also, it is surprising how many nurses will be moved to sympathy and will feed a woman in labor unless progress is quite swift.

It must be assumed, therefore, that the woman in labor has food in her stomach. If she is made unconscious, vomiting or unrecognized regurgitation frequently occurs during induction and maintenance of or emergence from anesthesia, and a small amount of this irritating material on the vocal cords or in the air passages may easily cost her life. Even if the problem is not gastric contents, serious respiratory obstruction may attend loss of consciousness.

Recommendations:

(1) Use anesthetic methods which permit the patient to remain conscious whenever possible. Any of the inhaled agents may be used for analgesia without producing loss of consciousness; and if episiotomy is to be performed, the area may be injected with local anesthesia, or pudendal block may be performed. This provides all that is necessary in most obstetric cases. Occasionally an operative delivery may require deep surgical anesthesia. Manual removal of an adherent placenta is the only operation in which this is often required since podalic version has fallen into disfavor. At times forceps delivery may require surgical anesthesia, but this will be decreased in frequency and in depth of anesthesia required if local anesthesia is added.

(2) If unconsciousness must be produced, a delivery table should be used which permits lowering of the head so that foreign material drains away from the glottic opening. A suction apparatus which functions well and is immediately available should be provided. The anesthesia should be administered by the most experienced person available, not by some attendant, general nurse, or physician who is not accustomed to administering anesthesia.

(3) A dose of atropine or scopolamine should be given, preferably 20 minutes before anesthesia, to minimize secretions

which frequently attend the efforts of inexperienced anesthetists.

(4) The patient's breathing should be observed very closely. If it is not free and effortless, the jaw should be pulled forward in an effort to lift the relaxed tongue from the pharynx and relieve the respiratory obstruction. If this is not successful, the mask should be removed from the face and an attempt made to introduce an artificial airway into the mouth. If the jaw is not relaxed, then a soft rubber tube may be inserted through the nostril into the pharynx. Even if there are no signs of secretion or vomitus in the pharynx, it is a good idea to lower the head of the table and to insert a suction tip into the pharynx. Sometimes foreign material escapes notice, or the mechanical manipulation may induce the patient to breathe or cough, thereby improving the situation.

The choice of apparatus through which to administer the anesthetic drug selected depends largely upon what is available. In general, less trouble will be encountered if the apparatus is kept simple and easily managed. For example, ether or chloroform may be dropped on an open mask, or a simple inhaler such as is now frequently used with trichloroethylene may be used. With these methods the source of oxygen is room air. During an emergency is not the proper time to learn the workings of a complicated anesthesia machine.

(5) When in doubt about the patient's condition, there is little to be lost by removing all apparatus and allowing the patient to breathe air.

Spinal Analgesia

Since the patient may be left conscious with this method and since the perineal muscles are well relaxed, it might be considered ideal in obstetrics. However, there are disadvantages in almost everything. Severe headache may follow spinal analgesia and is a strong deterrent to its use in many localities.

An even more dangerous complication, though more easily prevented, is total respiratory paralysis due to high spreading of the anesthetic solution. This seems to occur more easily in the woman in labor than in a nonpregnant person. It probably has something to do with the altered dynamics of spinal fluid due to the abdominal tumor and uterine contraction. Also, such small doses of anesthetic drug are required that it is easy for mistakes to occur and overdoses to be given. This paper is not meant to encourage the use of spinal analgesia but instead to call attention to its dangers. Any physician wishing to employ it should obtain instruction in its use from someone quite experienced. He should be prepared to administer artificial respiration adequate to maintain life for several hours since it may take that long for the drug to wear off and respiration to resume. There is no justification for letting a woman die from respiratory paralysis due to high spinal analgesia!

Caudal Analgesia

This block produces conditions for delivery as ideal as spinal analgesia and has the advantage of not being complicated by headache. With both forms the perineal muscles are so well relaxed that spontaneous rotation of the head and delivery rarely occur, and delivery must usually be by instrumental means. It is not an easy block to perform, especially in the woman in labor who may have much edema and fat over her sacrum. It is also possible, by using a needle longer than 3 to 5 cm., to perforate the dural sac and, with the comparatively large volume of solution (15 to 25 cc.) needed for this block, to produce total spinal block, which will produce death quickly if artificial respiration is not instituted.

It is doubtful if caudal block will receive wide use until the number of physicians trained in anesthesia is much greater.

Local Infiltration

With the advent of two drugs, Xylocaine and Cyclaine, which take effect very rapidly and spread well through tissue, local infiltration should find wider acceptance. These drugs, used in a 1% concentration with epinephrine added, will produce good analgesia which only rarely will wear off before the episiotomy is repaired. This may be reinforced by injecting 10 cc. of the solution in the region of each ischial spine to block the pudendal nerves. This produces more muscular relaxation than simple infiltration of the episiotomy line.

Fetal Distress

When it has been necessary to give a mother deep surgical anesthesia, the baby's absorbing a significant amount of the drug is unavoidable. If this anesthesia is added to preliminary sedation, apnea may occur for several minutes after birth. If there has been an obstetric complication which deprives the baby of oxygen in utero; for example, separation of the placenta or obstruction of the umbilical cord, the baby may have made efforts to breathe before birth. The result may be a large amount of inhaled amniotic fluid and blood together with fetal asphyxia. If such infants are to be saved and not have cerebral damage, they must have the foreign material removed very promptly and artificial respiration begun at once. If the attendant knows how to intubate the trachea, this may be done; but frequently it is as effective to remove what material may be quickly aspirated from the pharynx and then, with the baby suspended by the feet to prevent forcing secretion deeper into the lungs, to blow gently into the infant's mouth with one's own lungs. This should be done frequently, using just enough pressure to inflate the lungs. Often more liquid will drain out of the lungs with institution of artificial respiration. This can be removed from the pharynx and the artificial respiration continued.

Conclusions

1. A plea has been made that making a woman in labor unconscious be considered a hazardous procedure, that a person competent to administer general anesthesia be obtained if at all possible, and that a tilting delivery table and suction apparatus be available in the event of vomiting or regurgitation.

2. In the event that total respiratory paralysis complicates spinal or caudal analgesia, life should be maintained by adequate artificial respiration. Compression of the chest does not produce "adequate" artificial respiration. The lungs should be inflated rhythmically, and mechanical gadgets should not be relied on.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association, which will be held in the Hotel Statler, New York, May 28, 29, and 30, 1957, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the association.

FISKE ESSAY ON INFERTILITY

The trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce as the subject for this year's dissertation "The Present-Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin
Guest Editor: Joseph M. Lubitz, M. D.

Report of a Case*

Dr. John G. Frisch (Resident in Urology): This 55-year-old white male entered the hospital on Feb. 6, 1953, because of urinary frequency. Approximately one year prior to admission the patient had noted nocturia two to three times, and he had noted a dysuria of 15 to 30 minutes for the past six months. He also noted a decrease in the size and force of his stream. Some urgency and incontinence was also present. In 1935 the patient had had a cerebrovascular accident resulting in a left hemiparesis.

The remaining portion of the examination and history was noncontributory. Physical examination revealed a well-developed, well-nourished, obese, white male in no acute distress. The blood pressure on admission was 160/80, and the pulse was 84 and regular. The examination was essentially negative, except for the prostate, which was noted to be somewhat enlarged but of normal shape and consistency. A two-glass urine test was negative. There was 565 cc. of residual urine present. Laboratory work on admission revealed the nonprotein nitrogen to be 33 mg.%, the hemoglobin to be 13½ gm., and the white blood cell count and differential to be normal. Urinalysis showed a 4 plus sugar. Urine cultures on admission revealed *Streptococcus faecalis* and hemolytic *Staphylococcus aureus*. The blood sugar was 280 mg.%

Hospital Course: Because of a high blood sugar, diabetic consultation was obtained; it was recommended that the patient be placed on 25 units of protamine zinc insulin a day. Approximately 10 days after hospital admission an elevated temperature to 101 F. developed. Excretory urograms were negative. X-ray examination revealed pneumonitis in the left base. After this subsided, the patient was scheduled for a transurethral resection; but he became very apprehensive and nausea and vomiting developed so the procedure had to be cancelled. One week later a transurethral prostatic resection was performed. During the procedure it was noted that the patient's blood was dark and the plasma contained hemoglobin.

On the second postoperative day oliguria developed. No plasma hemoglobin was present. The nonprotein nitrogen was 57 mg.%, carbon dioxide 18.9 mEq., blood chloride 85.6 mEq., and hemoglobin 8 gm. Because of only 50 cc. of urinary output, the patient was placed on a Bull diet. Fluids were restricted. The first day he was given 1,000 cc. of 5% glucose in water, 500 cc. of sixth molar lactate, and 100 cc. of blood. He was placed on regular insulin, and this was given as the blood sugars were obtained.

The nonprotein nitrogen on the fourth postoperative day was 112 mg.%, carbon dioxide was 24.3 mEq., chloride 85.6 mEq., and blood sugar 204. The daily output of urine for the fifth, sixth, and seventh days was 500 cc., and by the ninth day the patient had put out 900 cc. of urine per day. The regime of restricted fluids, replacing only insensible loss and adding enough fluids to keep the patient hydrated and to keep electrolytes in balance, was maintained. On the eighth postoperative day the electrolytes were within normal limits. The nonprotein nitrogen at that time was 280 mg.%.

On the thirteenth postoperative day the patient put out 1,400 cc. of urine. However, it was noted that the urine was of low specific gravity, varying from 1.005 to 1.012. The nonprotein nitrogen was 298 mg.%. During this period of diuresis the patient received around 3,000 cc. of intravenous fluid per day. His serum potassium levels varied between 4.2 and 5.2 mEq. during the entire postoperative period. However, his condition did not improve; he became semicomatose, and azotemia persisted in spite of adequate urinary output. The nonprotein nitrogen remained elevated around 260 mg.%, even though the patient put out as much as 2,700 cc. of urine in one day. Several tracheobronchial toilets were per-

* From Veterans Administration Hospital, Wood.

formed because of marked respiratory distress. The patient expired on the thirteenth postoperative day.

Dr. Thomas E. Nesbitt (Attending in Urology): This is a very interesting case from a urological standpoint. It embraces many facets of renal physiology which are of grave concern to us all. On the surface, it appears to be an obvious case of acute renal failure. But, to begin, we should consider the various aspects of the case which bring us to that conclusion.

First of all, the pertinent facts from the history are that the patient was a middle-aged man who had had severe symptoms of prostatism. In 1935 he had a cerebral vascular accident which left him with a left hemiparesis. He was a known diabetic patient.

The significant physical findings were an enlarged prostate gland noted on rectal examination, and a blood pressure of 160/80. The laboratory work on admission showed a normal hemoglobin of 13 gm. and a normal nonprotein nitrogen. The patient did have a 4 plus sugar on urinalysis, but his diabetes was apparently satisfactorily regulated before surgery. From what I have been told, this problem was managed during his period of anuria by judicious administration of insulin and by frequent blood sugar determinations. Assuming this to be the case, it would appear that this factor probably does not enter into the picture. There is one significant point in the laboratory work; namely, the urine culture, which showed a hemolytic *S. aureus* and *S. faecalis*. This, I think, should be borne in mind.

During the patient's course in the hospital he had normal excretory pyelograms although a urinary tract infection was shown by culture. Pneumonitis developed which subsided with treatment, and I understand about a month elapsed before specific transurethral surgery was performed.

Now, let's consider certain facts concerned with the course of his surgery that are missing from the protocol. It would be very nice to know whether or not this patient had any blood transfusions during surgery. If he was under a spinal anesthetic and received a transfusion, did he manifest any reactions? If he did not, then one possible cause of renal shutdown can be eliminated. Secondly, during the immediate or late postoperative period, did the patient have a febrile reaction? We know that he had organisms cultured from the urine, although they might have been contaminants. However, these were *S. faecalis* and hemolytic Staphylococcus, either of which could become virulent to the patient if he were to suffer bacteremia.

We are told that on the second postoperative day the patient became anuric. It was noted during surgery that the blood was dark, and free hemoglobin was found in the plasma.

Causes of Acute Renal Failure

What are the causes of acute renal failure? What do we know about it? It seems worth mentioning that the older term, lower nephron nephrosis, has been pretty well discarded by most renal physiologists today in preference to acute renal failure, as the lesions are not necessarily confined to the lower nephrons. One of the foremost workers in this field is Dr. Jean Oliver, who has meticulously teased out individual nephrons for extensive morphologic study of the actual disease process in this clinical entity. He has described two specific types of kidney injury in patients with acute renal failure. One is called a nephrotoxic lesion, consisting of epithelial necrosis without destruction of the basement membranes and principally confined to the proximal convoluted tubules. This is a diffuse lesion in that all the nephrons are involved. It is believed to be due to poisons on the renal epithelium and is seen in such conditions as mercury poisoning. To reiterate, this is a diffuse lesion involving all the nephrons which is limited to the proximal convolution, with destruction of the epithelium but without destruction of the basement membranes.

Opposed to this is another type of lesion seen in acute renal failure, termed tubulorhexic. Basically, it is what has been called lower nephron nephrosis in the past, as it is seen in the crush syndrome, transfusion reactions, sulphonamide poisoning, and similar conditions. It results in a disruption of the entire tubule wall, with epithelial necrosis and disruption and destruction of the basement membranes. It is not a diffuse lesion involving all the nephrons, but is a patchy lesion felt to be due to patchy areas of ischemia throughout the kidney. This, then, is the type of injury we see in transfusion

reactions and in situations producing intravascular hemolysis.

Where does this enter into the picture of a patient who has had a transurethral prostatectomy? Some 10 years ago Doctor Creevy at the University of Minnesota became very interested in this problem because of several deaths following transurethral surgery attributed to acute renal failure. He studied all his patients who were subjected to transurethral prostatectomy and found that from 30% to 70% of them at some time during the surgery exhibited evidence of hemoglobinemia. His work was reported and confirmed by studies at several other institutions. This was the first evidence pointing to the danger of distilled water as an irrigating fluid for transurethral surgery. When it is realized that during the course of surgery large veins may be opened in the prostatic capsule, allowing distilled water to enter the vascular bed, it is understandable why intravascular hemolysis may occur. The reaction to this theory has been that if a third of these patients have hemoglobinemia, why don't more of them evidence anuria, with acute renal failure? This can be answered by considering other factors, one of which is the bacteremia that occurs during transurethral surgery. A study at the Mayo Clinic has shown that roughly 50% to 60% of the men subjected to transurethral surgery will have a positive blood culture in the few hours following or during the surgery. This transient bacteremia is ordinarily handled by the individual's own immune responses. Furthermore, the majority of these patients who come to transurethral surgery are in the older age group, and most of them have some degree of arteriosclerosis. The pathogenesis becomes apparent, then, under a given set of circumstances. For if one takes what would ordinarily be normally functioning kidneys, then superimposes on them some degree of arteriosclerosis, adds the possibility of mild shock reaction from hypotension during the course of surgery, further stresses them with a bacteremia, and then insults these kidneys by adding ischemia from intravascular hemolysis, it is readily conceivable that certain of these patients will develop an acute renal failure of the tubulorhexic type. That is the background of what may happen to a patient who has distilled water used as an irrigating fluid for transurethral surgery. In recent years, the use of distilled water for irrigating fluid has been abolished in this institution as in many other centers in favor of an isotonic, nonelectrolyte solution. There are several that are satisfactory, and the one in use is 1.1% glycine.

Management of Anuria

The next problem is management of the anuric patient, and the first question which naturally arises in cases of postoperative oliguric patients is whether or not the lack of urine formation is on a renal basis. Several things can be done to answer this question, the first of which is to check on the urinary specific gravity. If the patient is dehydrated and putting out small quantities of urine, the urine will be concentrated. If the patient has a renal shutdown and has acute renal failure, he will be putting out a dilute urine with specific gravity of 1.010 or 1.012. This is the simplest thing one can do.

One must also rule out the possibility of upper urinary tract obstruction secondary to such conditions as bilateral calculous disease, carcinoma of the prostate, and ureteral neoplasms. We know that in this case the patient had a normal upper urinary tract immediately beforehand, and there was no reason to suspect upper tract obstruction. The specific gravity was checked, and it was low. Intravascular hemolysis was demonstrated. Therefore, we can say categorically that, at least initially, this man had acute renal failure. Whether or not he had a superimposed bacteremia is impossible to say as we have no information regarding a febrile response.

It should be remembered that if such a patient were to have a severe bacteremia superimposed on acute renal failure, it might produce multiple cortical abscesses. The clinical picture of diffuse cortical necrosis, as this is termed, can be almost identical to that of acute renal failure except for the fact that the patient will run a severely septic course and will tend to produce small quantities of urine in decreasing amounts because of extensive destruction of glomeruli. Also, ordinarily these patients fail to progress to the diuretic phase as this is a universally fatal entity. It would appear that we are not dealing with such a process in this instance as there is no history of sepsis.

The management of acute renal failure can be quite difficult but, when properly car-

ried out, it results in an over-all recovery rate of approximately 75%, without resorting to the use of an artificial kidney. There are several essential points in the management of these patients which are worth reviewing. Initially, one should set up for the patient's record a very accurate account sheet of intake and output. Preferably, this is placed on the front of the patient's record, where it is immediately available at all times. The intake record should include not only the amount but an analysis of the character of the fluid in regard to its electrolyte content and approximate caloric content. The output record should include not only information about urinary output, but accurate estimations of stool, vomitus, and gastric secretions. On the same chart for each day a space should be allowed for recording pertinent blood chemistry determinations.

A second point which should be stressed is an accurate daily weight determination. It is worth noting that there are many people who feel that this is the most singularly important information which can be obtained about any patient who presents a fluid balance problem. To be properly carried out the patient should be totally stripped and weighed daily on the same scale. If a patient is observed to gain 2 kg. per day in weight during acute renal failure, fully 1 kg. can be attributed to simple fluid retention.

The next step in management is a limitation of the patient's fluid intake to what we term insensible body water loss plus an amount of fluid equivalent to the previous day's output of urine, stool, vomitus, and gastric secretions. This sounds relatively simple but in actuality is the one phase of treatment requiring the utmost in caution. There is a tendency to overhydrate the patient in acute renal failure, with subsequent pulmonary edema. It has been calculated that in the normal individual, insensible water loss amounts to ½ cc. per kg. of body weight per hour per day. In an average man weighing 70 kg., this would amount to 35 cc. per hour or 840 cc. per day. We may fail to realize, however, that the patient in acute renal failure has an accumulation of body water from the catabolism of carbohydrates, fats, and proteins amounting to from 700 to 800 cc. per day. This danger of overhydration becomes apparent when we consider that in the past the average patient in acute renal failure more often than not would receive 900 to 1,000 cc. of supplemental fluid each day to replace so-called insensible loss plus an equivalent amount of fluid to replace urinary output and vomitus, plus his daily accumulation of 700 cc. per day from catabolism of carbohydrates, proteins, and fats. In most instances it would mean that this individual would acquire at least an additional 2,000 cc. of fluid per day under what we had considered rational conservative management. We also know that these patients in most instances can readily develop pulmonary edema from as little as an additional 500 cc. of fluid added to their extracellular fluid compartment. As a result most men in renal physiology feel today that we should arbitrarily limit the intake of water to between 400 and 500 cc. per day. This refers to the administration of water usually as 5% or 10% glucose in distilled water and not in an electrolyte-containing solution, for ordinarily electrolytes are not administered except when there has been a loss of electrolytes from the body, as from vomiting or diarrhea.

A fourth objective is to maintain an intake of at least 100 gm. of carbohydrates per day. This is ordinarily accomplished by the use of 10% glucose plus oral administration of various accepted mixtures. The maximum protein-sparing action of carbohydrates is accomplished with 100 gm. This should be attained insofar as possible to spare protein catabolism and the subsequent accumulation of nitrogenous products. Frequent blood chemistry determinations are, of course, invaluable in following the electrolyte pattern and, when feasible, should be obtained every two or three days. The judicious administration of antibiotics is also felt to be therapeutically sound, for certainly the patient in acute renal failure is less resistant to secondary infections.

The program of management we have outlined was followed pretty accurately for the most part in the patient we are discussing today, except for the administration of fluids. We asked for an accurate listing of the daily intake and output from the patient's record and requested that it be posted on the blackboard as you see. It is to be noted that rarely on any day was the administered water under 2,000 cc., and in defense it can also be said that the patient be-

gan putting out some quantities of urine. It must be recalled, however, that when there has been a destructive lesion of the nephron with loss of epithelium and dissolution of the basement membrane, a period of 10 to 12 days will elapse before there is any regeneration of the epithelium, and even then there is no cytological maturation of the epithelium insofar as enzymatic activity is concerned. As a result, the kidney in this early recovery phase fails to concentrate the urine and not only loses water but electrolytes as well. These patients tend to exhibit some degree of hyponatremia; and when the diuresis begins, it is imperative to supply electrolytes. However, the amounts of urine being formed by this man in the few days preceding his demise never exceeded 2,000 cc. per day, yet I understand that he received fairly large amounts of salt-containing solutions intravenously during this time. Because of the precarious balance existing, it seems likely that this amount of electrolyte simply served to expand his extracellular fluid compartment tremendously, with resultant pulmonary edema. In other words, it would appear this patient was drowned, so to speak, by his own fluid from extensive administration of water and salt over and above his urinary output when it seemed spontaneous diuresis was beginning.

Other statistical data such as the blood nonprotein nitrogen level should also be considered. Certainly these individuals die in what is termed a state of uremia, but we know that the actual urea accumulation is of no significance. The important factors are the fluid and electrolyte derangements and the accumulation of other toxins. Just what these toxins are no one actually knows. In this regard, it may be that ammonia plays a role, for there is a definite syndrome attributed to ammonia intoxication seen in some patients with cirrhosis who have been subjected to porta-caval shunting operations, and certain aspects of the patient in acute renal failure distinctly resemble this syndrome. The remainder of the blood chemistry determinations were within fairly normal limits, and the problem of hyperkalemia did not develop. Low hemoglobin levels were noted, and this may possibly have been a factor although it appears unlikely.

To conclude, it is my impression that this patient died from overhydration due to extensive administration of fluid and electrolytes during the beginning recovery phase, with death attributable to pulmonary edema. The singularly important factor which we do not know is whether he exhibited sepsis throughout his hospital course after becoming anuric; if this did occur, our presumptive diagnosis might be altered to some extent.

Dr. Donald A. Franklin (Resident in Internal Medicine): Were any electrocardiograms taken to determine the potassium level?

Dr. Reuben Beezy (Ward Physician): It has recently been shown that the electrocardiogram does not accurately reflect the potassium level and, at most, may only indicate a metabolic derangement.

Doctor Lubitz: Do patients in renal failure die because of the hyperkalemia?

Doctor Nesbitt: Certainly the potassium levels are followed closely with electrocardiograms and serum levels. Personally, I cannot recall a death from acute renal failure directly attributable to hyperkalemia, although I am certain it may possibly occur. With serum levels of 8 to 8.5 mEq., one should institute measures to reduce the potassium concentration.

Pathological Findings

Doctor Lubitz: On external examination there was evidence of edema of the wrists and the malleolar area. Both lungs were heavy. The right weighed 940 gm. and the left 980. There were dense adhesions of the right lung to the thoracic wall, and the left lay free. The densities seen by x-ray were accounted for by the presence of plaques on the pleural surface rather than within the parenchyma. The lung tissue itself showed marked pulmonary edema. In the left lower lobe there was an area of induration which indicated bronchopneumonia. The heart weighed 400 gm. The coronary vessels showed severe calcification. The myocardium was flabby and brownish in color. The aorta showed aneurysmal dilatation of the descending thoracic portion which grossly had the appearance of findings in syphilis. Other portions showed atherosclerosis with ulceration. The liver weighed 2,815 gm. and

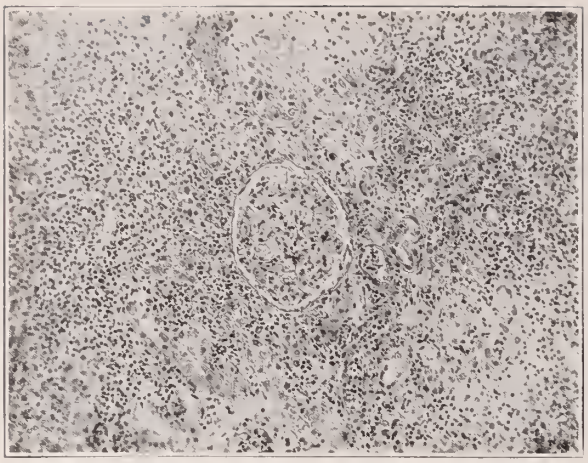


Fig. 1—Photomicrograph of kidney, showing diffuse leukocytic infiltration (X 105)

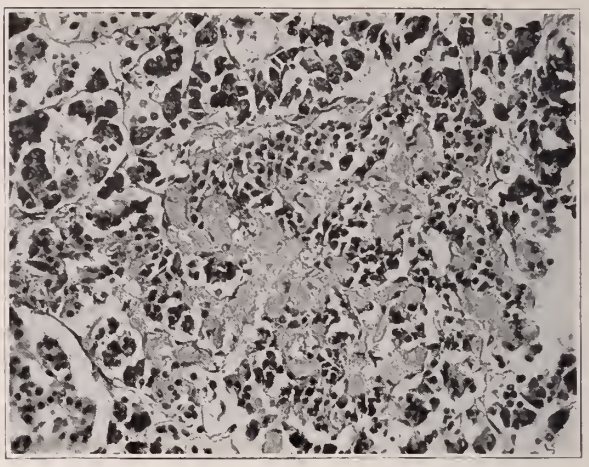


Fig. 2—Photomicrograph of pancreas, showing hyalinization of islet of Langerhans (X 480)

showed parenchymatous degeneration. The spleen weighed 570 gm. and was septic. The adrenal glands were not changed. Both kidneys were large, and each weighed approximately 500 gm. In attempting to remove the kidney, induration was found surrounding both kidneys. As the capsule was stripped, cavities of pus from ½ to 2 cm. in size were encountered. The kidneys themselves were pale and swollen and showed gross and microscopic findings of inflammatory reaction (fig. 1). The ureters were both dilated. The urinary bladder was thickened, papillary, and red in color. The prostate gland was replaced by abscesses. The pancreas grossly showed nothing unusual, but microscopically showed hyalinization of the islets, as is often found in diabetes (fig. 2). The brain showed edema, small hemorrhages, and multiple small areas of demyelinization which was on a vascular basis.

When the material from the perirenal abscesses was cultured, the following organisms were found: *Proteus mirabilis*, *Aerobacter aerogenes*, and *Paracolobactrum aerogenoides*. Sensitivity studies showed that *P. mirabilis* was sensitive to Chloromycetin; *A. aerogenes* to Aureomycin, Terramycin, and Chloromycetin; and *Paracolobactrum* to Aureomycin, Terramycin, and Chloromycetin. All were resistant to Ilotycin. The patient received Aureomycin two months before his exitus, and toward the end he got penicillin, Gantrisin, and streptomycin. These drugs were not effective for the bacteria found at autopsy examination. Microscopically, the kidneys showed abscesses. If the patient had so-called lower nephron nephrosis due to the hemolysis, it was completely masked by the inflammatory changes. Therefore, whereas he may have had acute renal insufficiency from lower nephron nephrosis, we must attribute the final renal failure to the infection, which in a diabetic patient is not unusual. For some reason we are seeing more and more infections of the urinary tract with coliform bacteremia in diabetic patients today. Doctor Nesbitt, would you care to conclude the session?

Doctor Nesbitt: The pathogenesis is now very clear. It seems likely that the man initially had an ischemic insult to the kidneys from intravascular hemolysis, followed by a septicemia with subsequent development of diffuse cortical necrosis and extensive parenchymal destruction. Perhaps administration of the antibiotic of choice would have been of value; but with such a fulminating infection, it seems doubtful that the eventual course would have been significantly altered.

Dr. William C. Webb (Resident in Internal Medicine): Should any diabetic patient undergoing instrumentation be given prophylactic antibiotics?

Doctor Nesbitt: That is an excellent point. As a general rule, I am reluctant to administer antibiotics to anyone until he exhibits clinical signs of infection, relying on the individual's own ability to effectively combat most new organisms to which he may become host. Whether this is the proper approach or not I don't know. On the other hand, the poor-risk patient or sick patients, such as those with diabetes, who are known to have

decreased resistance to invading virulent organisms might well be given prophylactic antibiotics. It would seem the more conservative approach is preferable, and one should be selective in such matters for we all condemn the random, injudicious use of antibiotics in light of our increasing knowledge on this subject. The development of resistant strains and alterations of normal bacterial flora patterns is a real clinical problem. But, for the average patient in otherwise good health, it seems wiser to be on the alert for infections and, when they appear, to treat them vigorously according to the offending organism with the antibiotic of choice.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

The first-prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held at the Hotel William Penn, Pittsburgh, May 6–9, 1957.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

THESE GUIDES MAY HELP YOU

The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
4. **Guide for the Development of a Local or Regional Rheumatic Fever Program**—Recommendations for a model plan of rheumatic fever program emphasizing the convalescent home, diagnostic and follow-up clinics, and a home-service program.
5. **Hearing Conservation Programs for Wisconsin Industries**—Some recommended standards and principles for providing a hearing conservation program in industry.
6. **Industrial Health, A Guide for Medical and Nursing Personnel**—General principles and suggested procedures for an industrial health program, especially in relation to standing orders for nurses.
7. **Medical Care of Migrant Agricultural Workers**—A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.
8. **Minimum Standards of Medical Care for County Hospitals**—A guide to physicians and county asylum superintendents concerning medical care for patients in county hospitals.
9. **Participation by Physicians in Radio and Television Programs**—A guide to physicians and county medical societies for their presentation of or participation in radio and television programs.
10. **Planning Your Career as a Medical Associate**—A brochure to acquaint young people with the careers open to them in fields related to medicine.
11. **School Health Examinations**—A guide for physicians and school authorities in establishing a program of school health examinations.
12. **School Vision Screening Program**—An outline to facilitate the development of a program to detect significant visual defects among school children.
13. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**—A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

Control of Diabetes

As It Looks to Your State Board of Health

THERE are one to two million known persons with diabetes in the United States today. It is predicted that there will be an increase in the number of cases because of a number of factors, the most important of which are the decrease in maternal and infant mortality, increased longevity of persons with diabetes, an aging population, and no known method of prevention. It is estimated that there are 100,000 new cases of the disease yearly.

Diabetes is now the eighth leading cause of death in the United States. For some reason or other, there is a higher mortality in urban areas, and the north central and eastern states also seem to have a higher mortality. Insulin has reduced the death rate both in children and adults.

There is a familial tendency evident in this disease, as it is four or five times more frequent among blood relatives. So it is important, when a member of a household is diagnosed as having diabetes, that all members of that home be checked repeatedly for early diagnosis of diabetes.

Obesity is another factor in connection with the disease, with 70 to 80% of those with diabetes being overweight. It is also more frequent in white married females who have had children.

Economics plays an important role in diabetes. Diabetic patients are disabled from work about 50% of the time. About half of the known cases require insulin for the control of the disease. The average cost to a person with diabetes because of his affliction is $13.50 per month. This is just for minimum maintenance and does not take into consideration hospitalization for complications.

From a medical and public health viewpoint there are three means of attacking the problem. They are:

(1) Research as to the etiology and therapy of the disease
(2) Education of the public, the professions, and the patient
(3) Early detection.

There being no preventive measures against this disease, early detection becomes the most significant factor in its control. The doctor's office is most important in early detection. Mass screening programs for the detection of diabetes are not as profitable a case-finding method as routine examinations in the physician's office, the hospital, or the clinic. However, the educational value of such programs should not be overlooked.

Early detection and proper control of diabetes when diagnosed are important because of the many complications that may occur. These include:

(1) Renal arteriosclerosis occurs much earlier in patients with diabetes, without regard to age or hypertension. It is present in 75% of diabetic patients above the age of 50.

(2) Fatal coronary disease is more frequent in diabetes.

(3) Diabetic retinal hemorrhages absorb and disappear slowly, if at all.

(4) Neuropathies occur only in uncontrolled or poorly controlled cases of diabetes.

(5) Skin and urinary infections, the most common of the infectious processes, are always serious.

(6) Tuberculosis is another common infection in patients with diabetes. So tuberculin testing should be done periodically on juvenile patients with diabetes. Proper treatment of diabetic symptoms improves a case of tuberculosis.

(7) Babies of diabetic mothers may die from hypoglycemia without ever showing signs or symptoms of the condition. Some authorities routinely give 50% glucose by dropper and bottle the first few days of life. Some do a blood sugar determination immediately on newborn infants and repeat every 15 minutes for the first two hours.

Once a case of diabetes is diagnosed, diet is the basis of treatment. Oral preparations with hypoglycemic effect have been developed in Germany and France. They are being produced and used experimentally in this country. Although their present status is not clear and their toxic effects over long periods of time have not been determined, they may prove to be useful in cases of mild diabetes not requiring insulin for control.—G. G. SHIELDS, M.D., *District Health Officer, Wisconsin Rapids.*

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Chlorpromazine Jaundice

With a bewildering flood of new drugs and modifications of old ones pouring from the laboratories, each new agent carries a potentiality, all too often realized, of its own new illness, and unpleasant surprises seem inevitable. Chlorpromazine, a brilliantly effective weapon in such areas of distressing therapeutic impotence as intractable vomiting and incapacitating mental and emotional disturbances, predictably achieved widespread and at times perhaps uncritical acceptance. It was to be expected that some patients would be inconvenienced by such pharmacologic side effects as drowsiness, gastric distress, constipation, dry mouth, and tachycardia, and that occasional cases of agranulocytosis, dermatitis, and drug fever would occur. Even the very rare appearance of a picture simulating Parkinsonism caused little concern. As numerous instances of jaundice were recorded, reaction was immediate, however, and some alarmists even refused to employ the drug at all.

It is estimated that from 1 to 5% of those patients who receive chlorpromazine develop jaundice. Inadequate records and lack of criteria which will easily differentiate certain other forms of hepatitis preclude a really accurate figure. Jaundice may appear a week or two after the drug has been discontinued, and not uncommonly the patient has consulted a new physician at this time and is unaware of the nature of his previous medications. All these factors tend to further obscure the true incidence of this condition.

Typically, a rather nonspecific reaction, characterized by malaise and fever, with at times anorexia, nausea, vomiting, headache, chills, pruritus, and enlargement or tenderness of the liver, is seen during the second or third week of chlorpromazine administration, to subside in a few days as jaundice appears. This "chlorpromazine illness" may occur without succeeding jaundice, or icterus may develop without antecedent systemic reaction. Eosinophilia is frequent but not always present. The laboratory usually reports those findings characteristic of obstructive jaundice: elevation of total and direct-reacting bilirubin, alkaline phosphatase, and often total serum cholesterol; cephalin–cholesterol flocculation and thymol turbidity are usually negative. Slight elevation of the serum globulin is not uncommon. The depression of fecal urobilinogen may approach that seen in carcinomatous biliary obstruction. Some patients who are closely followed may show eosinophilia, elevation of alkaline phosphatase, or bilirubinuria in the absence of either subjective symptoms or jaundice. Examination of tissue obtained by liver biopsy characteristically shows centrolobular pigment deposit with bile plugging of canaliculi. The parenchymal cells are generally intact, though tiny areas of focal necrosis are sometimes present. There is a cellular infiltrate in the portal areas in many, but not all cases, and at times the infiltrate contains a number of eosinophils, a finding which is quite suggestive of the specific etiology. The larger bile ducts appear quite normal.

The duration of the jaundice varies from a few days to several months. It seems probable that the vast majority of patients recover completely, but experience to date does not permit exclusion of the possibility that the hepatic lesion contributes to an occasional death or results in permanent hepatic injury in some instances. Much more frequent are those situations in which failure to recognize the process or insoluble diagnostic difficulty has led to biliary tract exploration in a seriously ill patient.

The current frequency of this condition is such that it should receive careful consideration in the evaluation of every jaundiced patient; any unidentified medication should be suspect. Minimal dosage, short periods of administration, or discontinuance of the drug, if it has been within the period of the

preceding two weeks, gives no insurance against this possibility; jaundice has appeared within 24 hours after the initiation of therapy and after doses of no more than 30 mg. per day. It should be remembered that very similar processes may occur without obvious cause and may be the result of a viral infection or treatment with methyl testosterone, para-aminosalicylic acid, thiouracil, organic arsenicals, and perhaps certain other drugs.

Concern as to this hazard should dictate careful weighing of the indications for chlorpromazine therapy but should by no means prevent its use where the benefit to be derived justifies a limited risk. There is no proof that this risk is increased significantly in patients with pre-existing liver disease, nor does previous chlorpromazine jaundice mean that recurrence is inevitable if the drug is reintroduced, although considerable caution is definitely in order. Perhaps the most important lesson to be drawn from experiences with this drug is re-emphasis of a truism. Despite the commendable trend of drug manufacturers toward careful clinical investigation prior to open sale of a new agent and their increasing willingness to publicize undesirable effects and untoward complications in their advertisements, every physician who elects to employ a new drug has very real responsibilities. These are, first, to acquaint himself fully, from reliable and disinterested investigative reports, with the known actions and side reactions of the drug and, second, to maintain close and critical observation of the patient receiving it, so that unanticipated effects may be promptly recognized and appropriate action taken. Conversely, in any unusual illness, thorough questioning as to any recent medication or possible exposure to chemical agents which might exhibit toxic effects is in order, and careful evaluation of the possible importance of any agent, the effects of which have not been extensively explored, is indicated.—J. L. Sims, M.D.

SYMPOSIUM ON IMMUNOLOGY

Presented by the MILWAUKEE ACADEMY OF MEDICINE

Place: MARQUETTE UNIVERSITY BROOKS MEMORIAL UNION
Date: SATURDAY, DECEMBER 1, 1956—9:00 A. M. to 4:00 P. M.

FACULTY

Frank J. Dixon, Jr., M. D., Professor and Director, Department of Pathology, University of Pittsburgh School of Medicine

T. N. Harris, M. D., Associate Professor of Immunology in Pediatrics, University of Pennsylvania

William B. Sherman, M. D., Associate Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons

Carl V. Moore, M. D., Dean, Washington University School of Medicine

Theodore L. Squier, M. D., Associate Clinical Professor of Medicine, Marquette University School of Medicine

All Physicians Are Welcome To Attend *No Registration Fee*

Luncheon will be served at the Union. Reservations may be made by writing to the Milwaukee Academy of Medicine, 561 North 15th Street, Milwaukee 3, Wisconsin.

Programs may be had upon request.

A RESEARCH MILESTONE

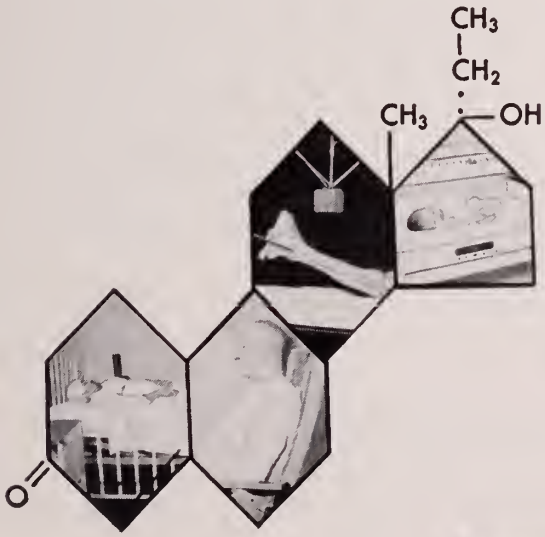
Nilevar*

(BRAND OF NORETHANDROLONE)

Searle's New and Practical Steroid Specifically for Protein Anabolism–

It has long been recognized that a substance which would promote protein anabolism would be of inestimable value in therapy. The androgens have this property, but unfortunately they also exert actions on secondary sex characteristics. These effects are commonly undesirable in therapeutic programs.

THE FIRST STEROID WITH ANABOLIC SPECIFICITY—Nilevar, the newest Searle Research development, therefore, meets a long desired clinical need because Nilevar presents the first steroid primarily anabolic for protein synthesis. Moreover, Nilevar is without prominent androgenic effects (only about one-sixteenth of that exerted by the androgens).



OBJECTIVE AND SUBJECTIVE RESPONSE – Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

WELL TOLERATED—Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

MAJOR INDICATIONS—Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

SUPPLY—Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

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SEARLE

Prescribe Journal-advertised products and you prescribe the best.

. . . . THE PRESIDENT'S PAGE . . . .

Speaking of Income . . .

THE amount of disability among my colleagues in Wisconsin never ceases to amaze and startle me. For example, our Society staff in Madison reports that one out of every six or seven physicians was sufficiently ill or injured last year to become eligible for benefits from the Society-sponsored disability program. These doctors received benefits ranging from a few dollars to more than $10,000.

These statistics tell only part of the story. A physician has an unusual economic problem. He lives almost entirely by his personal art and the skills of his hands and mind. His income is directly affected by his ability to see patients at home, in the office, and at the hospital. His reputation, too, is affected by his availability for practice. It is no wonder that loss of income through disability is one of the most serious hazards confronting members of our profession.

Six years ago these facts prompted the State Medical Society to develop a group sickness and accident insurance plan. There is no doubt that the opportunity to participate in this plan is one of the most important benefits of Society membership. The Council and a special committee of the Society spent more than 18 months working out details of the plan so that it would do the right kind of job for Wisconsin doctors. The Provident Life and Accident Insurance Company of Chattanooga was unanimously selected as the carrier.

The Society's planning was thorough and sound. Because this is a true group plan, the program offers benefits designed for doctors at a cost considerably lower than that we would pay as individual physicians. Also, because it is a true group plan every actively practicing member of the Society was offered the opportunity to participate without a health statement during the initial enrollment period in 1950. Since that time, new Society members under 32 years of age have been given one year in which to apply without health questionnaire, and those over 32 have six months to apply. A doctor who does not purchase the program when it is first offered him may apply later, but a health statement is required. To date more than 75% of the actively practicing physicians in Wisconsin have become participants in the plan.

Recently, the Provident Company assigned an experienced representative to Wisconsin as a means of increasing service to participants in the plan by way of handling claims and giving information about the terms and benefits of the policy. He is using the Society office as his headquarters, and the Council of the Society has urged him to call personally upon Society members throughout the state. He will present an introductory card bearing the name and seal of the State Medical Society of Wisconsin. His time is valuable, but he realizes that your time is even more so. His visits will be brief and to the point. Should he stop at your office, I feel certain that it will be to your advantage to see him as quickly as possible.

One thing is most important. The State Medical Society's income protection plan is top-notch basic protection. If you don't have a sickness and accident plan of any kind, the Provident plan should be your starting point. If you have other plans, keep them but add the Society's program. There are many advantageous health and sickness policies, especially those sponsored by county societies or specialty groups. Few members of the medical profession carry adequate disability insurance.

If you feel that you must choose between plans, you'd be wise to learn the full story of the State Medical Society plan straight from the representative.

Remember, for the younger practitioner, the Society's plan is an excellent foundation; for the older physician, it is a valuable supplement to other insurance already in force.

L. O. Simenstad M. D.

More than 75% of the Practicing Doctors in Wisconsin

are now enrolled under

THE INCOME PROTECTION PLAN

especially designed for you by

your state society

If you are not now enrolled write

STATE MEDICAL SOCIETY OF WISCONSIN

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The plan is underwritten by

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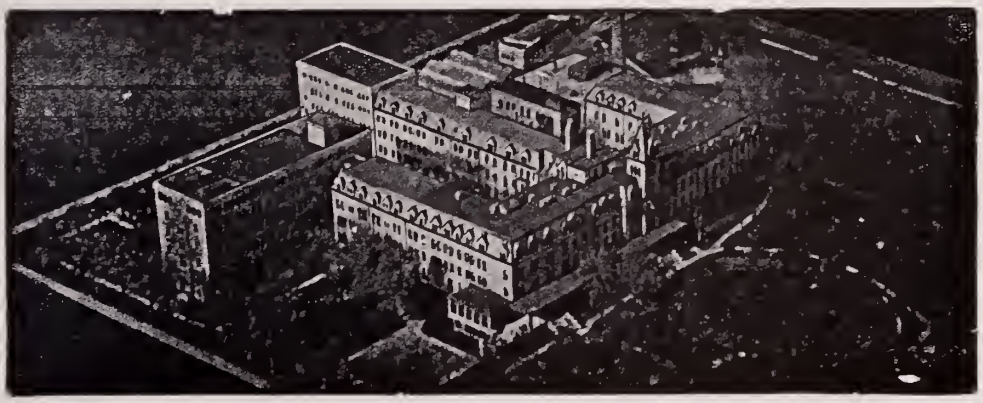

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MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Literature and rates sent on request.

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Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
John R. Whitty, M. D.

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Contributions to the Medical History Section of The Wisconsin State Historical Society show much variance. For example:

This year Mrs. George Funne, Osceola, donated three medical instruments and pill cases with contents. These had been used by her father, Dr. Henry E. Comebacker. Dr. J. S. Mills, Cincinnnati, Ohio, sent in a medical pamphlet on "Use and Abuse of the Bicycle." Mrs. Ingolf Roe, Stoughton, contributed two 1897 drugstore advertisements which appeared in the Stoughton weekly.

Here are others:

A pamphlet, "Fifty Years of Medicine in Retrospect," prepared by the late Dr. Joseph Lettenberger of Milwaukee, sent in by Mrs. Lettenberger. Eighteen office ledgers from the early 1900's, from Mrs. Marcus Bossard of Spring Green. She also sent in three medical kits, a box of pictures, and miscellaneous medical items.

Mrs. George Carnell, Racine, forwarded pictures of the first drugstore in Milwaukee, early U. S. tax stamps, and several boxes of patent medicines of a half century ago. Mrs. Dodd Kanouse, Spring Green, sent in dental office equipment, including a laughing gas dispenser.

* * *

The accompanying picture shows Dr. Drexel L. Dawson, who died this year, and Dr. Olaf M. Sattre (at the wheel), who died in 1941, with an unidentified man who usually served as driver for the physicians (right). The vehicle was a snowmobile which was equipped to utilize skis on the front wheels when the winter going was rough.

Doctor Dawson started his practice in Rice Lake in 1915, following internship at Cook County Hospital. Saloons and roistering were plentiful in the upstate community when he came. He also found need for a hospital, and he and Doctor Sattre worked together to get one.

Often the two physicians would deliver babies in cold farmhouses, with only a frightened father or neighbor on hand to assist. Roads were seldom plowed, and the physicians called on the snowmobile in winter and a motorcycle with a sidecar in spring and fall. A shovel and other tools were standard equipment. Doctor Dawson also used sleighs and horseback for his calls.

Doctor Dawson served on the Rice Lake school board, as health officer, and in various other community capacities. He served in both world wars.

While still a young man, he was accepted as a Fellow of the American College of Surgeons. He worked on a special state legislature committee with Dr. Otto Bock to settle a dispute on the basic sciences and was an active member of his state and county medical societies. He was among the first in the state to use spinal anesthesia and spinal punctures.

Friends said Doctor Dawson was quite fearless in what he thought was right and proper and labored unceasingly to further the causes he believed in.

* * *

Have *you* given thought to joining the Section on Medical History? Dues are $5 annually, and the benefits and satisfactions are many. Send a note to the Society office, with your check, and it's done.

THE MEDICAL FORUM

COLOR TV TO BE FEATURED AT ANNUAL MEETING OF SMS IN 1957

MADISON—Color television will be featured at the 1957 Annual Meeting of the State Medical Society in Milwaukee May 7–9, a plan developed by the Council on Scientific Work this summer.

The advent of color TV marks a development in the meeting program, and promises to offer a wide variety of surgical and medical subjects to those attending. Arrangements are being made to telecast closed-circuit programs twice daily from Milwaukee County Hospital.

COMMITTEE ACTIVE

A local committee, appointed by **Dr. M. G. Rice**, Council chairman, is working with representatives of Smith, Kline and French, Philadelphia pharmaceutical firm, to initiate the program.

Committee members include Drs. Joseph King and Francis Murphy, of the Milwaukee County Hospital; Mark W. Garry and Miles B. Smith, Veterans' Administration Hospital, Wood; J. C. Peterson, Children's Hospital; E. T. Harrington, of the Wisconsin Academy of General Practice; Maurice Hardgrove, the Wisconsin Society of Internal Medicine, and a representative of the Wisconsin Surgical Society.

Preliminary plans have been drafted for the entire Annual Meeting program, which will feature *"General Practice Day"* on May 7, and specialty programs on obstetrics, gynecology, pathology, surgery, pediatrics and anesthesia May 8, and on internal medicine, radiology, orthopedics, psychiatry, ophthalmology and otolaryngology on May 9.

Commenting on the arrangements, **Dr. L. G. Kindschi**, Monroe, general program chairman, said:

VARIETY A GOAL

"We know from responses of members to our 1956 program that the return of specialty meetings offered a broader base to our program than in several years past. With the continued fine cooperation of specialty societies, and the Wisconsin Academy of General Practice, in making the Annual Meeting an official function of their groups, we will be able to provide a better program for a larger percentage of our members.

"We feel that color TV has much to offer. We feel confident that this will heighten interest in our 1957 program."

The Council authorized establishment of awards to scientific exhibits, a plan designed to provide more recognition for this feature. It is anticipated that the winners will present papers concerning these exhibits for publication in the *Wisconsin Medical Journal*. A maximum of $500 annually will be set aside to encourage committees and divisions to develop education displays in special fields. A maximum of $100 to any one group is to be made available.

Dr. M. F. Huth, of Baraboo, is chairman of scientific exhibits for the 1957 session.

ALUMNI GATHERINGS

Special scientific meetings will be scheduled for May 8 and 9, with luncheons for alumni of the medical schools of Marquette University and the University of Wisconsin developed for May 7.

Special meetings for new members, the **Charitable, Educational and Scientific Foundation** and the **Section on Medical History** will be held again next year.

Pre-meeting events will include a meeting of the Wisconsin Chapter of the American College of Chest Physicians May 5, and the golf tournament May 6.

Dr. Nereim

W.A.G.P. Names Dr. T. J. Nereim President-Elect

MILWAUKEE — The new president-elect of the Wisconsin Academy of General Practice is **Dr. Theodore J. Nereim** of Madison.

Named at the annual convention of the W.A.G.P. here Sept. 16–18, Dr. Nereim has been a member of the group's board of directors. He will take office next September, succeeding **Dr. Robert F. Purtell**, Milwaukee, incoming president this fall. Dr. Purtell took over for **Dr. Raymond R. Richards** of Eau Claire.

Others elected were *Dr. Edgar End*, Wauwatosa, secretary–treasurer; **Dr. C. F. McDonald**, Milwaukee, speaker of the congress of delegates; *Dr. Royden F. Collins*, Madison, vice speaker; **Dr. Richards**, delegate to the annual meeting of the American Academy of General Practice; *Dr. A. J. Sanfellippo*, Milwaukee, alternate delegate; and **Drs. Walton R. Manz**, Eau Claire; *Charles Picard*, Superior and **George Handy**, Wisconsin Rapids, to the Academy board.

The WAGP voted to give its delegate at the national meeting a free hand in deciding policy on post-graduate medical study requirements for members in the general practitioner organizations.

Currently, the groups require 150 hours of such study every three years as a condition for continued membership. At the most recent A.A.G.P. session, there was pressure to relax this requirement. *Several W.A.G.P. members commented that this should be continued or stiffened, rather than relaxed.*

A Forum Feature . . .

WIDE PROTECTION OFFERED IN NEW INSURANCE PLAN

"Package" Plan For Homeowners Shows Merit

MADISON — There is an entirely new concept in homeowners' insurance.

In one policy, with *one* premium to pay, you can have, commercial insurance firm proponents say, "the protection you need for your *home*, your *personal property* and *personal liability*."

It's called the multiple peril plan and is described as *"the modern way, the convenient way to buy protection at lower cost than these same needed policies on an individual basis."*

BEING OFFERED

Paul J. Rogan, State Commissioner of Insurance, reports that most major casualty insurance carriers are offering the program, and that the State Commission is watching it as an experiment.

The plan also has been described as one in which overlapping coverages are eliminated, and the assured has but a single company to deal with in event of a claim under the contract.

This *"package"* protection is taking hold because of the convenience factor. As stated, there is only one premium to pay, and only one renewal time instead of several. Economies in handling make savings possible, too. The right *"package"* for your individual requirements also is possible.

UNDER SURVEILLANCE

At present, the Wisconsin Insurance Department is observing carefully the experience under the recently introduced types of coverages. As this becomes available, the rating plans will be reviewed to reflect the actual indicated experience.

"If it can be demonstrated that the principles involved in package policies are sound, such principles will be applied to the extent necessary so that rates continue to meet the standards of the rating law," Rogan commented.

The policies are designated as home owners A, B and C. A and B

Mr. Rogan

afford certain peril coverages for the assured's property together with residence liability coverage. Home owner C affords all risk coverage for property plus residence liability coverage. A is somewhat limited, B affords broader coverage and policy C the widest type of protection, insuring all risk of loss except flood, earthquake and normal wear and tear on property.

COVERAGE DETAILED

Here's what's covered:

In Your Home: Fire and extended coverages protect against nature's furies, such as lightning, hurricanes, wind and hail. Internal perils such as water and smoke damage, explosions, freezing and the like. Also covered are glass breakage, falling objects and aircraft damage and more.

Your Personal Property: Fire and extended coverages protect jewelry, furs, cameras, sports equipment, etc. Plus loss due to theft, robbery or burglary.

Your Personal Liability: Comprehensive insurance protects you against claims arising out of accidents on your property or situations in which your family may be involved. If a guest is bitten by your dog, you're covered. If your golf ball strikes another golfer, you're covered, and so on.

TO LOCK OR . . .

To illustrate the variance between plans B and C:

Under B, your car has to be locked to be covered under theft protection. Under C, it isn't necessary to have it locked to be covered.

One estimate in premium cost savings was given at 20 per cent. This was based on judgment and is intended to reflect, Rogan said, (a) the savings in expense resulting from issuance of a single policy in lieu of several; (b) an anticipated reduced loss ratio from a greater spread of risk; (c) elimination of adverse selection resulting from the mandatory inclusion of identical coverage in all policies, and (d) anticipated additional premiums obtained from insuring property for a higher percentage of actual values.

INFORMATION AVAILABLE

Policies are written for a three year period.

Information relative to the "homemakers' package" may be obtained from the State Insurance Commission in Madison or any major insurance firm.

National Medical Assistants Group To Meet Oct. 26–28

MILWAUKEE—More than 300 delegates from all sections of the United States are expected to attend the first annual American Association of Medical Assistants convention here Oct. 26–28.

Secretaries, receptionists, nurses, technicians and other employees of doctors of medicine are eligible to be members of the component state medical assistants' societies.

Assistants, whether they are members of the Wisconsin State Medical Assistants Society or not, and Wisconsin physicians, are welcome to attend the sessions at the Pfister Hotel. The Wisconsin group is host to the annual gathering.

Top speakers at the sessions will be **Dr. J. E. Manning**, Saginaw, Mich., on the subject, *"The Ideal Medical Assistant,"* and the **Rev. Fr. Joseph Holleran**, pastor of St. Jude's Catholic Church in Milwaukee, on *"People Are People."*

Other events on the program will include special tours, luncheons and social gatherings.

The Association held its organization meeting a year ago.

INTEREST WAS VERY HIGH—at the State Medical Society's display at the Wisconsin State Fair in West Allis in late August. The display was "Life Begins," showing the full story of conception and birth of the human being. Thousands of visitors took time to study the fetus stages which were imbedded in plastic (left and right photos) and many mothers and fathers utilized the presentation to explain in detail the miracle of birth to their youngsters (center picture). Several visitors told S.M.S. staffers who manned the booth: "This helps us immeasureably. It answers many questions and aids us in getting away from the fable of the stork's role in human birth." This was the first time the pictorial portrayal of birth was shown in Wisconsin.

Physicians Forum Again Plugging for M.D. Social Security

CHICAGO — The Physicians Forum is up to old tricks again.

The group recently mailed a four-page brochure to every physician in the country, passing the hat for funds to finance a campaign to get social security for doctors.

The brochure carries the name of a committee urging support for the proposal.

Physicians Forum was once led by the late Ernest P. Boas of New York. Labelling itself the *"voice of the liberal doctor,"* the organization championed the fight in behalf of the Wagner–Murray–Dingell bill providing for compulsory national health insurance. In 1945 the Forum issued a statement, declaring:

BACKED TRUMAN

"We strongly approve the message of Pres. Harry S. Truman calling for the establishment of a nationwide health and medical care program to supply the medical needs of all Americans regardless of income, race and religion."

Dr. George F. Lull, secretary and general manager of the A.M.A., commented recently:

"The response from doctors this time will probably be no better than it was in 1952 (when a similar brochure was distributed). Too many honest and sincere physicians recall the activities of the Physicians Forum a few years back."

Public Relations Recipe

Proof-is-in-the Pudding

Take one (1) county medical society.

Add one (1) active public relations committee and one (1) informed membership.

Work hard, with enthusiasm.

Serves entire community.

Refute Claims of "Cures" by Writer Of Arthritis Book

NEW YORK CITY—The American Rheumatism Association has refuted statements made in a nonfiction best seller, *"Arthritis and Common Sense,"* written by Dan Dale Alexander.

Asked for a statement by editors of the *New York Times*, the Association declared:

"The author's statements regarding some of the symptoms that indicate arthritis, or a tendency to arthritis, are not based on scientific fact. Arthritis in all forms is difficult to treat under the most favorable conditions.

CAUSED CONFUSION

The problem becomes even more complicated when its investigation and treatment are confused in the minds of the public by misleading fads and fancies.

"Although the author claims that many people have written him, stating that they have been 'cured' of their arthritis by following his recommendations, such statements must be carefully examined."

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE

policies are not terminated nor are benefits reduced because of age.

T·I·C·

TIME

INSURANCE COMPANY

MILWAUKEE WISCONSIN

PHYSICIANS ARE TAKING MORE ACTIVE ROLE IN TELEVISION AND RADIO

MADISON—Physicians and medicine are becoming more and more popular as subjects for radio and television programs.

Established programs on a country-wide basis did much to initiate this trend, and to influence the viewing habits of the American public.

Here are some good examples of airing well-devised medical information programs in Wisconsin:

The Dane County Medical Society arranged recently for a series of five mental health programs to be presented this summer on WHA–TV, Madison. Each program is a half hour presentation, and pin-points a phase of mental illness in a forceful graphic manner. The series represents material from a national network effort, The March of Medicine, and was made available through the A.M.A. and the Smith, Kline and French Laboratories.

The Medical Society of Milwaukee County has been active for several years with various programs on a number of local radio and TV outlets. Response has been most encouraging.

The Marathon, Dane and Brown-Kewaunee–Door county medical societies arranged for showing the State Medical Society's own March of Medicine, a 12-part kinescope series of half hour length, for TV stations in their areas during the past year.

The series is available to any society wishing to utilize it in Wisconsin. It covers a wide range of health problems, including arthritis, allergies, heart disease and diabetes.

The State Medical Society every month sends out a dozen "spot" announcements, varying in length from 30 to 90 seconds, for use by radio stations in Wisconsin. Such subjects as polio, home accidents, first aid, quackery and cleaning out medicine cabinets are covered.

For any county medical society to embark on a radio or TV program, it is of extreme importance that certain basic fundamentals are understood and followed. The meaning of the term, *public service time*, for instance, should be fully known.

Some persons believe that stations are obligated to devote a certain portion of broadcast time to public service activities, with the Federal Communications Commission wielding the big stick. **This is not the case.** The best broadcasters, however, know the wisdom of a good balance between commercial and public service time . . . and map schedules accordingly.

Almost all station officials realize the tremendous amount of material available for broadcast in conjunction with local medical activities.

Most of them are cooperative in allocating time for medical matters. They want the programs organized well, of interest to a wide range of viewers and listeners, and they do not want to be high pressured into agreeing to cooperate.

The State Medical Society has available copies of a guide, **"Participation by Physicians in Radio and Television Programs,"** which was approved by its Council on Medical Service. Also available is **"Guiding Principles for Participation in Telecasts and Broadcasts,"** as approved by the A.M.A. Board of Trustees last November. Both are very helpful.

The Society has lists of films which may be utilized on the programs conducted on local levels. Staff members stand ready to cooperate in staging and producing programs at all times.

The Society also would appreciate being informed of county medical society plans and activities in radio and television.

County Med Societies C–D Meeting Planned

CHICAGO — The annual conference of the County Medical Societies Civil Defense Organization will be held at the Morrison Hotel Nov. 10–11.

Dr. Charles P. Anderson, of Detroit, program chairman, said a practical and informational session had been arranged, including workshop activities covering developments and projects around the country.

Physicians assigned to mobile medical teams and members of the State Medical Society of Wisconsin Committee on Civil Defense are invited to attend.

Mr. Jost

Jost Joins Staff As Fieldman

MADISON—Lee Jost, Milwaukee, has joined the State Medical Society staff as district Blue Shield sales coordinator and field representative for S.M.S. in southeastern Wisconsin. His office will be in Kenosha.

Jost, second place winner in the Hearst National Oratory contest in 1950, received his master's degree from Marquette University two years ago. In 1952 he represented the United States at the Selphic Festival of Theater Arts in Freiburg, Germany.

His record shows teaching experience at two Milwaukee high schools and at Marquette University.

Jost served two years in Korea with the 7th Division Infantry.

Speakers Available On Chest Diseases

MILWAUKEE — The Wisconsin Trudeau Society recently announced its speakers' bureau stands ready to bring speakers on pulmonary diseases to meetings of county medical societies.

Dr. Helen A. Dickie, Society president, said it was the goal of the group to stimulate interest of Wisconsin physicians on modern methods of therapy involving tuberculosis and other chest diseases.

Subjects will include differential diagnosis, cardiopulmonary function estimations, best use of antimicrobial drugs, use of chest surgery, place of the sanatorium today in treatment of chest disease and allied material.

Requests for speakers should be addressed to **Dr. Dickie, c/o** W.A.T.A., 1700 West Wells Street, Milwaukee.

Code- E - Excellent
G - Good
F - Fair
P - Poor

EVALUATION REPORT

Medical Exhibitors Association Inc.
P.O. Box 872, Villanova, Pennsylvania

REGISTRATION:
Physicians..... 1717
Others..... 1035
Exhibitors..... 424
Total..... 3176

MEETING OF: STATE MEDICAL SOCIETY OF WISCONSIN
City: Milwaukee, Wisconsin
Date: May 1 - 3, 1956
Exhibit Hall: Milwaukee, Auditorium
Average cost per front ft. $ 18.00

SUMMARIZED GENERAL INFORMATION

Number of exhibitors 89
Number reporting 80

Was porter service good? In Yes Out Yes Was lighting good X bad ____

Were charges for special services reasonable? Yes X No ____

Were there intermissions to visit exhibits? Yes X No ____ How long AM- 30 to 45 minutes PM- 45 minutes

INDIVIDUAL RATING OF MEETING	Pharmaceuticol				Book Publishers				Equipment				Foods				Surgical Supplies				Miscellaneous			
	E	G	F	P	E	G	F	P	E	G	F	P	E	G	F	P	E	G	F	P	E	G	F	P
Suitability of city	29	13			2	2			8	4	1		7	3			3				6	2		
Suitability of exhibit hall	29	13			2	1		1	8	5			5	5			3				4	4		
Your hotel accommodations	9	10	6		1	2			2	4			1	7				2			3	2		
Physicians' interest in exhibit	15	17	9	1		4			2	11			3	6	1		1	2			1	5	2	
How was the circulation of Physicians in exhibit hall	15	17	9	1		3		1	1	9	2	1	2	6	2		2	1			1	5	2	
Sales of your products (Report only if sales is the prime reason for attending meeting)	1					3	1		3	2	2							2	1			1		1
How do you classify this meeting	12	23	6	1			4			11	2			8	2			3			1	6	1	
Would your experience at this meeting lead you to recommend that your firm exhibit next year?	Yes 39		No 3		Yes 4		No		Yes 13		No		Yes 10		No		Yes 3		No		Yes 8		No	

GENERAL COMMENTS:

Submitted by: _____

Company: _____

The Annual Meeting of the State Medical Society last May rated very well with exhibitors, according to a survey report of the Medical Exhibitors Association Inc. of Villanova, Pa. Highest ratings were listed for suitability of city and exhibit hall. Seventy-seven of 79 exhibitors recommended that their firms participate again in 1957, based on 1956 experiences. General handling of details and improvements made during the past year also pleased the exhibitors. They suggested that S.M.S. (1) alternate this meeting between Milwaukee and Northern Wisconsin to give physicians from all parts of the state a better chance to attend; (2) lengthen intermissions to give delegates additional time to view exhibits and (3) limit the loudspeaker to important announcements. The Association is an organization which works with exhibitors for purposes of information and education, services and general arrangements.

Continue Probation Of Polio Propagandist

MIAMI, FLA.—Duon H. Miller, elderly Coral Gables cosmetics manufacturer who has been stirring up trouble on the polio front for many years, was given another chance by Federal Judge E. C. Choate recently.

CONVICTED IN 1955

Miller was brought to trial for violation of probation imposed last year when he was found guilty of sending libelous and scurrilous literature through the mails.

Judge Choate continued Miller on probation, adding the conditions he dissolve his organization, *Polio Prevention Inc.*, and have nothing to do with any discussions or efforts centering around polio prevention.

Public Relations Recipe

Prize-winning P-R

I cup Policy.
I cup Performance.
1 cup Publicity.
Blend well-stirring constantly.
Season to taste.

You're Invited!

NASSAU, BAHAMAS—Wisconsin physicians are invited to attend the Bahamas Medical Conference here Dec. 1–15. Clinical demonstrations and lectures will be held at the new Princess Margaret Hospital.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

DR. ARVESON HONORED AT MANITOWISH

MANITOWISH WATERS — A joint meeting of the Commission on Medical Care Plans and the General Council Sept. 7–8 was the occasion for a tribute to Dr. R. G. Arveson of Frederic, Council chairman.

In testimonial to his 50 years of service to medicine, the two State Medical Society committees presented a plaque to Dr. and Mrs. Arveson denoting their high regard.

Dr. Arveson was president of the Society in 1940, has served on several Society committees, as mayor and school board member in Frederic, as a member of the University of Wisconsin Board of Regents and Board of Medical Examiners.

Dr. Gunnar Gundersen, La Crosse, chairman of the A.M.A. Board of Trustees, speaking at the testimonial dinner for the couple, said:

MANY TALENTS

"Dr. Arveson is a physician with time for the spiritual values of life. He is dedicated to his fellow citizens, and is a man of many accomplishments. This grand gentleman, aided much by Mrs. Arveson, has kept in tune with changing times, and has been a tower of strength for whatever cause he labored.

"Here we have a man of vision, a unique personality. He is truly a great man."

The Frederic physician "exemplifies the highest ideals of medicine, one who would make any sacrifice for public health, and there is no one we like more," Dr. S. E. Gavin, Fond du Lac, also a past Society president, declared.

Dr. L. O. Simenstad, Osceola, current Society president, called Dr. Arveson a "crusader, a leader who lives up to what he preaches and practices. We owe much to him."

The 1948 Society president, Dr. W. D. Stovall, Madison, director of the State Laboratory of Hygiene, described the honored guest *"as a man of many talents, who gave us much to cherish.*

"His leadership is remarkable, inspiring. He is a citizen as well as a doctor. He is a social spirit. He is everything a doctor should be. I hope the tradition he has set will live on with us in Wisconsin medicine."

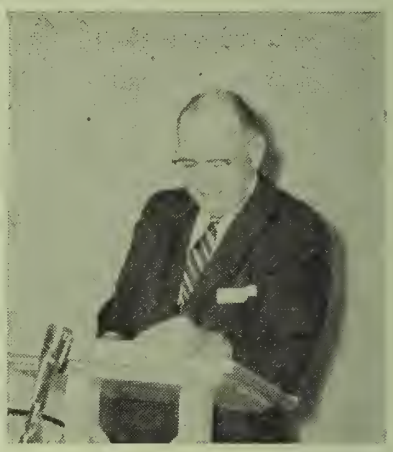
Dr. E. M. Dessloch, Prairie du Chien, chairman of the Commission on Prepaid Plans, said Dr. Arveson *"has made our lives richer, fuller, more meaningful. He is the man we love, a great man in medicine."*

If our leaders of the future have Dr. Arveson's interest, his solidarity and fraternal spirit, C. H. Crownhart, executive secretary and general manager of the Society, said, "medicine always will have free enterprise. He and Mrs. Arveson have contributed mightily to our Society, to their community and to others in so many ways.

"Dr. Arveson is a man so wonderful we can only follow in his footstep."

NOTE!

IT'S now the "COMMISSION ON MEDICAL CARE PLANS." Official action on changing the name of the Commission on Prepaid Plans was voted at a meeting of the General Council, with the Commission at Manitowish Waters Sept. 8. Because of the likelihood of the Commission working with the federal government on medical care for dependents of military personnel, the Council felt the new name would better describe the Commission's function and operation.



DR. J. W. FONS, of Milwaukee, was the presiding officer when the District X Blue Shield meeting was held in Madison Aug. 21. Subjects brought under discussion included district organization of both Blue Cross and Blue Shield, the role of the state medical society in Blue Shield–physician relations programs and improved liaison. Speakers included Leon R. Wheeler, executive vice president of Associated Hospital Service Inc.; Donald L. Taylor, executive secretary of the Iowa State Medical Society; Fredric P. G. Lattner, executive director of Hospital Service Inc. of Iowa, and Lawrence C. Wells, director of promotion services of the Blue Shield Commission. States represented at the meeting included Iowa, Wisconsin, Minnesota, North Dakota and Nebraska.

Public Relations Recipe

The P–R Chef—

Mixes patient, perseverance and public service philosophies with energy and enthusiasm. Takes any half-baked promotional scheme with a grain of salt.

MANITOWISH WATERS, SEPT. 6–8—The pictures on the adjoining page were taken at the joint meeting of the General Council and Commission on Medical Care Plans at Deer Park Lodge. No. 1 shows Mrs. and DR. R. G. ARVESON, Frederic, honored guests at a testimonial dinner marking the Council Chairman's 50th year in medical practice. No. 2 finds DR. ARVESON (center), with DR. J. M. BELL, Marinette (left) and DR. A. H. HEIDNER, West Bend, perusing the morning headlines before one of the meetings. DR. DEXTER H. WITTE (left), Milwaukee, introduces his associate, DR. DAVID W. OVITT, Milwaukee, in No. 3. In No. 4, DR. L. O. SIMENSTAD, Osceola (right), Society President, chats with DR. GUNNAR GUNDERSEN, La Crosse, chairman of the A.M.A. Board of Trustees, near the Blue Cross–Blue Shield Mobile Enrollment Unit. In No. 5, DR. E. M. DESSLOCH, Prairie du Chien, calls the session to order. With him are W. C. White (left), assistant secretary of S.M.S. and DR. ARVESON (right). Picture 7 portrays Paul R. Doege, in charge of Blue Shield sales for S.M.S., beside a display listing the various services of Wisconsin Physicians Service. Right below, No. 7, are two Kenoshans, obviously in a happy mood, DRS. DAVID N. GOLDSTEIN and LEIF H. LOKVAM (right). More serious (No. 8) are two commissioners from Milwaukee, DRS. RICHARD FOREGGER (left) and N. J. WEGMANN. At the top of the third column, DR. K. H. DOEGE, Marshfield (left), strides into the room with DR. ROBERT C. PARKIN of Madison. The ladies did much to brighten up things socially, witness. No. 10 with Mrs. G. W. Carlson, Appleton (left) and Mrs. E. M. Desslock, Prairie du Chien. DR. CARLSON observes and grins. Enjoying a good story (No. 11) are DRS. W. D. JAMES, Oconomowoc (left), E. M. DESSLOCH (center) and J. P. CONWAY, Milwaukee. DR. FREDERICK H. WOLF, La Crosse (right), passes the time of day in No. 12 with a newly-appointed commissioner, DR. J. H. HOUGHTON, Wisconsin Dells.

Health Plan Mobile Unit Makes Debut

MANITOWISH WATERS—Members of the State Medical Society got a first peek at the new Blue Shield–Blue Cross mobile trailer unit at a joint meeting of the General Council and Commission on Medical Care Plans here in September.

The unit is scheduled to begin its journeys around Wisconsin this fall.

Constitution, By-Laws Study to Continue

MANITOWISH WATERS—The Executive Committee of the General Council of the State Medical Society, meeting here Sept. 8, told the Society counsel and secretary to continue their study of a proposed revision of the organization's constitution and by-laws.

The Committee also voted allocation of $200 to help finance the annual Governor's Conference on Problems of An Aging Population.

"ON IMPACT"

MADISON—Findings on auto crash injuries, and the role played by physicians in working to prevent such accidents are depicted clearly in a new 15-minute film, "On Impact," recently made available by the A.M.A.

Parties interested in obtaining the film are urged to write the State Medical Society, Box 1109, Madison.

ON THE S.M.S. CALENDAR . . .

OCTOBER

18—Division on School Health, Whitewater
18—Conference on School Health, Whitewater
19—Joint meeting, S.M.S. Public Policy Committee and State Board of Medical examiners.
19—State Board of Medical Examiners, Madison (Reciprocity Examinations)
20—Committee on Military Medical Service, S.M.S.
22—National Blue Cross–Blue Shield Workshop Conference, Chicago
26—State Board of Health, Wales
26–28—First Annual Meeting, American Association of Medical Assistants, Milwaukee
27—Charitable, Educational Scientific Foundation Inc. and Executive Committee, Section on Medical History, S.M.S.
27—Division on Nervous and Mental Diseases, S.M.S.

NOVEMBER

1—Council on Scientific Work, Milwaukee
3—Study Committee, Maternal Mortality, S.M.S.
4—Division on Maternal and Child Welfare, S.M.S
6—Claims Committee, S.M.S.
8—Committee on Industrial Health, S.M.S.
10–11—North Central Conference, St. Paul
14—State Board of Health District Nurses' Association Training Session, Madison
15—Conference on School Health, Superior
16—Council on Medical Service, S.M.S.
17—Division on Public Assistance and Division on Rehabilitation, S.M.S.
25—Executive Committee, National Blue Shield Plans, Seattle
27–30—A.M.A. Clinic Session, Seattle
27—Circuit Program Lancaster
28—Circuit Program, Janesville
29—Circuit Program, Appleton

CAMBRIDGE—*"I just can't get used to all the room we have here."* That was the reaction of Dr. Karl K. Amundson, who began praticing in this community in 1914, to the new Cambridge Clinic.

The Clinic (pictured above) will house Dr. Amundson and his associate, Dr. James J. Nora, who joined him a year ago. Both are general practitioners.

"Practicing medicine in our new building is a pleasure," Dr. Amundson said. "It's still so new it hasn't had time to smell like a doctor's office yet."

Until moving into his new office, Dr. Amundson used an office which served his father, the late Dr. A. C. Amundson, since 1902.

The new building, 28x56 feet, is brick and redwood. It is air-conditioned, brightly lighted and best of all, Dr. Amundson says, *"it's roomy."* In addition to offices for the two physicians, there are treatment rooms, a business office, laboratory, an X-Ray room and a utility area. *(Wisconsin State Journal Photo)*

Council, Commission on Medical Care Plans Meet in Joint Session

MANITOWISH WATERS — A close-up view of how the Commission on Medical Care Plans *(formerly the Commission on Prepaid Plans)* functions was given the Society's General Council at a joint meeting here Sept. 6–8.

Council members heard Society Secretary **C. H. Crownhart** detail the history of the Commission, **Dr. E. M. Dessloch**, Prairie du Chien describe its operations and **Paul R. Doege**, staff sales director, outline sales activity.

Dr. R. E. Garrison, Wisconsin Rapids, presided over a meeting of the Commission's Enrollment and Underwriting committee; *Dr. G. W. Carlson*, Appleton, at the open session of the Physicians and Public Relations committee, **Dr. K. H. Doege**, Marshfield, at a meeting of the Research and Development group and *Dr. C. G. Reznichek*, Madison, at the Claims committee.

To Continue Study On Special Service Contract Benefits

MANITOWISH WATERS—The Executive Committee of the Commission on Medical Care Plans:

Decided at its meeting here Sept. 8 to study further a ceiling on benefits of the Special Service Contract. There is no specified maximum at present as to benefits other than the control the *Wisconsin Physicians Service* exercises in paying no more than usual, customary and reasonable fees of the medical community in which services are rendered.

Also indicated an interest in a plan of the Dairy Farmer Retirement Association Cooperative to devise a retirement income program for rural folk.

Journal Report:

Hypertensive symptoms relieved in 96% of patients

"Comparison of pentolinium [ANSOLYSEN] with other preparations in 25 patients with severe essential hypertension, for whom all other methods of management had failed, showed that pentolinium is the most effective of available agents in reducing dangerously high blood pressure to the desired levels, and in modifying some of the complications of hypertension, as cardiac decompensation, cardiomegaly and retinopathy. . . .

"In 96 per cent (24 patients) clinical symptoms were relieved and the blood pressure maintained at comfortable levels. . . ."[1]

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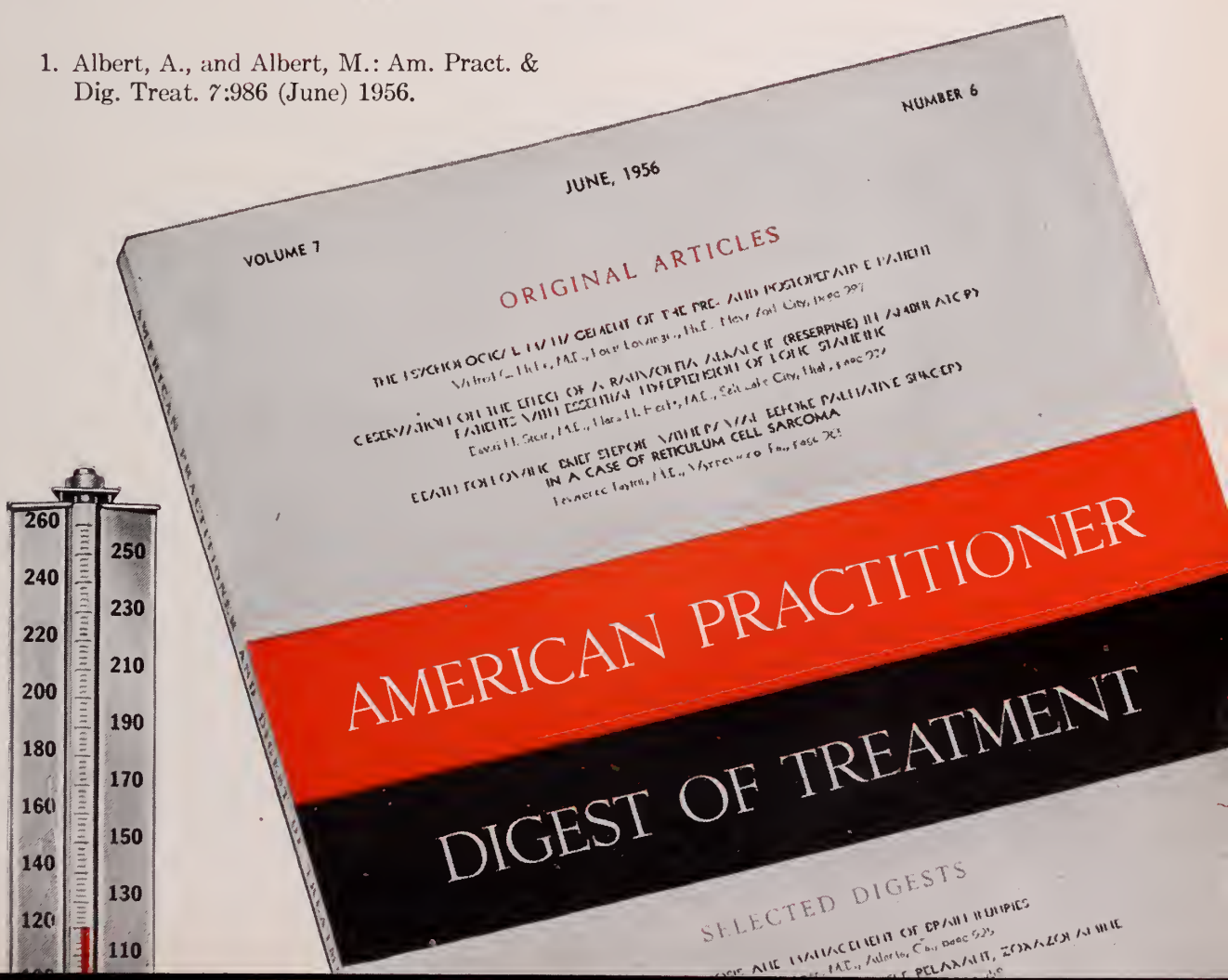
1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



THE WISCONSIN MEDICAL JOURNAL

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Volume 55 OCTOBER 1956 Number 10

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Functions of the State Board of Medical Examiners

The State Board of Medical Examiners of Wisconsin is comprised of seven licensed resident doctors of medicine and surgery and one licensed resident doctor of osteopathy, each appointed by the governor for a four-year term. No members are eligible who have, directly or indirectly, an interest in or connection with a medical school. The office of the Board of Medical Examiners is located in Madison in the State Office Building. The secretary of the board is a Madison resident. Such a combination insures the stability and continuity which were previously lacking. The office of the attorney general serves as legal counsel for the board, and one of its deputies is present at all meetings to offer guidance in the interpretation and administration of the statutes.

The primary purpose of the board is to license those who are properly qualified to practice in the State of Wisconsin. It intends to operate directly and precisely in accordance with the statutes. Certain rules, however, have necessarily been devised to interpret and implement the statutes in instances in which they do not apply specifically to a case in point. In cooperation with the Public Policy Committee of the State Medical Society, the board revised the Medical Practice Act in 1953 to conform with modern practice and concepts.

A new section of the act permits the board to issue temporary educational certificates to foreign graduates who may pursue postgraduate studies and training in approved teaching hospitals. The number is limited to 25 such graduates for one year and is not to exceed a total of 75 over a three-year period. The demand for foreign graduates is so great that the quota for 1956 was filled several months ago. A proposal is pending to increase the present quota to 100 by the revision of the Medical Practice Act. It is to be emphasized that our resident graduates do not compete with the foreign graduates. There is a continued demand for resident doctors who are graduates of our own schools.

A duty recently acquired is that of administrating a new section of the Medical Practice Act relating to the practice of physical therapy. The board has selected a state examining committee to assist in carrying out the provisions of the section. They are to be commended for their efforts, which have resulted in the efficient management of an entirely new licensing program.

Another revision in the Medical Practice Act permits the board to issue temporary licenses in emer-

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gency situations with specific and detailed restrictions. The board is determined that the privileges of temporary licensure will not be abused.

The board is also empowered to revoke or suspend the licenses of those who violate the provisions of the Medical Practice Act. They review many complaints and charges with respect to alleged violators. The board investigator and its individual members invoke the statutes whenever they are applicable. It is important to note that the board cannot proceed unless the charges can be substantiated and verified before a court of law. Direct evidence must be presented. Suspicions, allegations, and "cloakroom gossip" are not sufficient.

Another new function assigned to the board by the last revision of the Medical Practice Act is the conduct of registration of all persons licensed to practice medicine and surgery, osteopathy, or osteopathy and surgery. The secretary-treasurer is required to publish a printed list of those so registered and mail a copy to each person registered and to various state officials.

To add to its office efficiency, the board has acquired a new IBM machine. This equipment makes possible the sending out of the registration cards with automatic precision. The result is a reduction in some personnel and other expenditures. The office also boasts a new modern filing system.

The board expresses its appreciation to the officers of the State Medical Society, and particularly the Public Policy Committee of the Society, for their cooperation and endeavors in its behalf. A good feeling of mutual cooperation exists between the two organizations, and for this the board is grateful. Long may it continue.—J. W. McRoberts, M. D.

MEDICAL CONTINUATION COURSES TO BE PRESENTED AT THE CENTER FOR CONTINUATION STUDY, UNIVERSITY OF MINNESOTA

October 22–24	Gynecology for General Physicians
November 5–9	Radiation Therapy for Radiologists
November 19–21	Fractures for General Physicians
December 6–8	Physical Medicine
January 7–9	Dermatology for General Physicians

For further information concerning the above courses, write to the Director, Department of Continuation Medical Education, 1342 Mayo Memorial, University of Minnesota, Minneapolis 14, Minnesota.

DEARHOLT DAYS LECTURES

Roger S. Mitchell, M. D., a well-known Denver physician, will deliver the 1956 Dearholt Days lectures, the Wisconsin Anti-Tuberculosis Association has announced. The annual two-day lectureship will be held November 12–13 in Milwaukee and Madison.

Doctor Mitchell, professor of pulmonary diseases, University of Colorado, will address Milwaukee area physicians and Marquette University medical students at the medical school auditorium at 3:30 p.m., Monday, November 12, on the subject "Factors Influencing Relapse of Pulmonary Tuberculosis."

In Madison, on Tuesday, November 13, Doctor Mitchell will repeat his Marquette talk before the University of Wisconsin medical students at the Service Memorial Institute at 3:30 p.m.

At 8:00 p.m., Tuesday evening, he will discuss "The Significance and Handling of the Solitary Pulmonary Nodule" at the Madison VA Hospital Auditorium, 2500 Overlook Terrace. The lecture will be presented for physicians from Dane and surrounding counties.

Dearholt Days honor the memory of the late Hoyt E. Dearholt, M. D., WATA founder and executive secretary, 1910–1939. The two-day celebration brings outstanding leaders of the medical profession to Wisconsin's medical schools to provide supplemental knowledge in pulmonary diseases to physicians and medical students.

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1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.
2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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Society Proceedings

Kenosha

Thirty-six members of the Kenosha County Medical Society met September 6 at the Elks Club in Kenosha. Dr. D. P. Slaughter, professor of surgery at the University of Illinois, spoke on "Debatable Tumors."

Polk

The Polk County Medical Society met August 16 at Paradise Lodge at Balsam Lake.

Guest speakers at the meeting were Drs. W. H. Hengstler, St. Paul, who spoke on "Emotional Problems in Everyday Practice," and R. P. Flom, whose topic was "Use of Tranquilizers in Psychiatry." Following the addresses, a round-table discussion was held.

Eighteen members were present, and guests included Dr. Paul Simenstad of Osceola and *Dr. Dean Erickson* of St. Croix Falls.

Sauk

Members of the Sauk County Medical Society had a dinner meeting at the Hotel Warren, Baraboo, on September 11.

A. B. Abramovitz, Director of the Division of Child Guidance of the State Board of Health, discussed child guidance.

Wisconsin Academy of General Practice

Approximately 475 family physicians from Wisconsin attended the eighth annual scientific assembly of the Wisconsin Academy of General Practice, held at the Milwaukee Auditorium September 17 and 18.

The scientific sessions featured talks by specialists in a number of medical fields including surgery, obstetrics, and cardiovascular diseases.

Doctor Kenneth McFarland, educational consultant of the General Motors Corporation, was the chief speaker at the annual banquet, which was held at the Wisconsin Club.

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Association of Wisconsin Psychiatric Clinics for Children

On June 11, members of a number of Wisconsin psychiatric clinics for children met in Milwaukee for the purpose of forming the Association of Wisconsin Psychiatric Clinics for Children and adopting a constitution and by-laws for the association.

The purposes of the association are:

1. To provide opportunity for interchange of ideas and for mutual help in the study and solution of psychiatric clinic problems in Wisconsin.
2. To promote standards of training for clinic personnel.
3. To encourage research.
4. To carry on such other activities as may contribute to the total personality adjustment and happiness of the children of Wisconsin.

The following officers were elected to serve for a term of one year:

President—*Dr. Sara G. Geiger,* Director, Milwaukee County Guidance Clinic
President-Elect—Dr. Leland K. Reeck, Director, Dane County Child Guidance Center
Secretary-Treasurer—Marian L. Karr, Consultant, Psychiatric Social Work, Division of Child Guidance, State Board of Health
Members-at-Large—Luella Pesek, Clinical Psychologist, Racine Community Guidance Clinic; Max Kurz, Consultant, Psychiatric Social Work, Waukesha County Child Guidance Clinic

Personnel from 12 Wisconsin clinics, as well as members of the Division of Mental Hygiene of the State Department of Public Welfare and the Division of Child Guidance of the State Board of Health, participated in the meeting.

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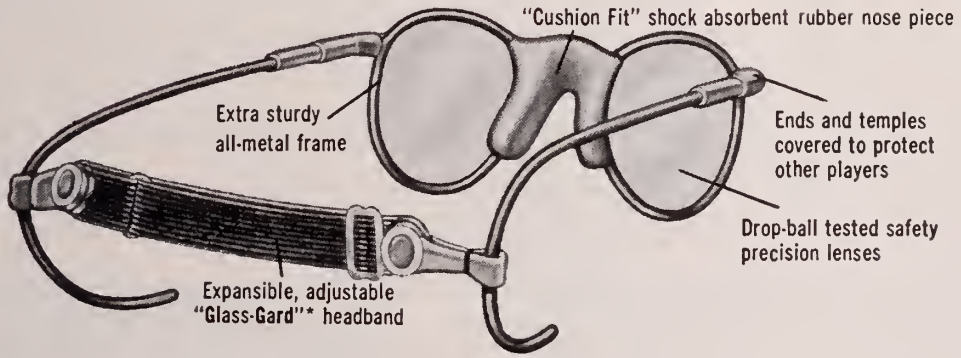

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News Items and Personals

Dr. Struthers Joins Stahmer Clinic

Dr. James L. Struthers recently joined the Stahmer Clinic in Wausau, where he intends to limit his practice to internal medicine and diagnosis.

Doctor Struthers is a 1950 graduate of the University of Illinois College of Medicine, Chicago. He served his internship at Milwaukee County General Hospital and also took his residency training there in internal medicine for three years.

For several months in 1953 and 1954, he was a staff member of the Milwaukee County Hospital for Mental Diseases.

Doctor Lavine Relocates

Dr. I. H. Lavine, formerly of Melrose, recently moved to Superior, where he will be in practice with his brother *Dr. Max Lavine.*

Doctor Lavine has been in practice in Melrose since 1931. At a farewell dinner held for Doctor and Mrs. Lavine, the people of the community presented them with a silver tray in memory of the occasion.

Dr. Olson Named World Medical Association Officer

Dr. M. H. Olson, Wittenberg, has been named Wisconsin chairman of the World Medical Association.

In October he will go to Cuba to attend the tenth general assembly of the World Medical Association, council meetings, and the Latin-American Hospital Association meetings. Following this he will go to New York City to attend other meetings.

Marshfield M. D.'s Receive Honorary Mention for Exhibit

Drs. Richard J. Rowe and *Harland C. Dangle*, Marshfield, received an Honorary Mention from the American Medical Association for their exhibit, "Dermatologic Lesions Seen in General Practice," which was presented at the meeting of the A. M. A. held in Chicago in June. Doctor Rowe was invited to present the exhibit at the Washington State Medical Association meeting held in Seattle in September.

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*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

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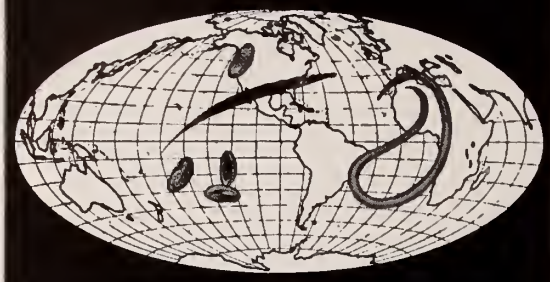

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New Physician in Lancaster

Dr. Warren W. Fieber joined *Dr. Robert D. Jackson* in general practice in Lancaster, Wisconsin, on September 15. Doctor Fieber is a 1955 graduate of the University of Wisconsin Medical School and interned at City Hospital, Winston-Salem, North Carolina.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Banyai Receives Medal

Dr. A. L. Banyai, Milwaukee, was presented with the Carlo Forlanini medal for his achievements in the field of tuberculosis at the closing session of the Fourth International Congress of the American College of Chest Physicians held at Cologne, Germany, recently.

Doctor Banyai, who is an associate clinical professor of medicine at Marquette University School of Medicine, developed pneumoperitoneum—injection of air under the diaphragm—to rest the lungs.

About 1,500 scientists from 63 countries participated in the four-day congress, which was the largest medical meeting ever held in Germany.

Dr. Overton Resumes Practice

Dr. R. S. Overton has recently been discharged from the armed forces, and has resumed his practice in Janesville. He served in the medical corps as a captain and was stationed last at Hawaii.

Dean Bowers Speaks in Watertown

Dr. John Z. Bowers, Dean of the University of Wisconsin Medical School, was the guest speaker at the weekly luncheon meeting of the Watertown Rotary Club on September 4.

Dean Bowers addressed the group on "Atomic Energy in Medical Research."

Reception Is Held for Dr. Coon

A farewell reception was held August 5 at University Hospitals, Madison, for *Dr.* and Mrs. *Harold M. Coon*. The event, which was open to the public, was given by hospital personnel.

Doctor Coon left Madison on September 1 to take over the superintendency of Milwaukee County Hospital, a position of the same type he has held at the University Hospitals.

Davis Brothers Resume Ophthalmologic Practice in Madison

An unusual, if not unique, occurrence in medical practice took place in Madison recently when the eldest and youngest sons of *Dr. Frederick A. Davis* joined him on the staff of the Davis & Duehr Eye Clinic, 224 West Washington Avenue.

F. J. Davis

Dr. Frederick J. Davis, the eldest, returned to resume his practice of ophthalmology after two years' active service in the Navy. He served with the rank of lieutenant commander as chief of the eye service of the U. S. Naval Hospital at Camp Pendleton, California.

In addition to his private service at the Davis & Duehr Eye Clinic, Doctor Davis will also return to duties as assistant professor of ophthalmology in the medical school at the University of Wisconsin and as attending ophthalmologist in the eye department of University Hospitals.

M. D. Davis

The younger son, *Dr. Matthew Dinsdale Davis*, will not only join the staff of the Davis & Duehr Eye Clinic but has received an appointment as instructor in ophthalmology in the eye department of the University of Wisconsin Medical School and will be associated with the Eye Clinic of the University Hospitals.

Dr. M. D. Davis received his Doctor of Medicine degree at the University of Pennsylvania Medical School and served an internship and residency at Wisconsin General Hospital. During his residency he was called to active duty with the Navy, in which he served for two years. He finished his naval service as chief of the eye service at the naval hospital at Bremerton, Washington.

He then completed his residency in the eye service at the University of Wisconsin and at Harvard Medical School. At Harvard and the Massachusetts Eye and Ear Infirmary, on a fellowship award from the Heed Foundation, Doctor Davis did basic work in ophthalmology as well as taking training in the newer techniques of retinal surgery.

Dr. Prouty Certified in Internal Medicine

It was recently learned that *Dr. L. R. Prouty*, who is associated with the Dean Clinic in Madison, was certified by the American Board of Internal Medicine on December 2, 1955. His subspecialty is cardiology.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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Dr. Hellmuth Panel Participant

Dr. George A. Hellmuth, director of the Cardiovascular Section of the Department of Medicine at Marquette University School of Medicine, participated in a panel on coronary disease at the twentieth annual meeting of the Mississippi Valley Medical Society held in Chicago on September 27. His topic was "The Complicating Thrombus *Per Se*." The panel was conducted by Dr. Paul D. White of Boston.

SOCIETY RECORDS

New Members

E. R. Brousseau, 515 Barstow, Eau Claire.

Gordon Davenport, Jr., 110 East Main Street, Madison.

V. G. Ward, 1710 Hoyt Street, Madison.

Changes of Address

C. F. Althaus, Hazel Green, to 374 West Washington Street, Sunnyvale, California.

J. J. Brook, Jr., Wauwatosa, to 20 South First Avenue, Sturgeon Bay.

W. E. Clasen, Dallas, Texas, to 3177 North 96th Street, Milwaukee.

G. M. Daley, Milwaukee, to MacCornack Clinic, Whitehall.

Shimpei Sakaguchi,** Long Beach, California, to 2338 North 59th Street, Milwaukee.

E. P. Schuh, Tigerton, to 706 Madison Street, Watertown.

I. H. Lavine, Melrose, to 1805 Hammond Avenue, Superior.

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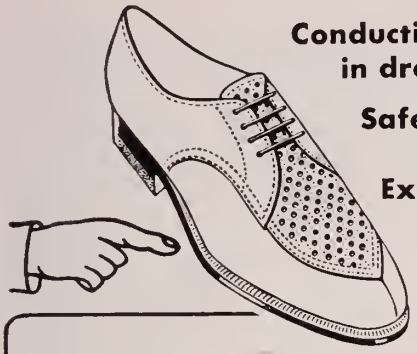

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Surgery of Colon & Rectum, One Week, October 15, November 26
General Surgery, One Week, October 29
General Surgery, Two Weeks, November 5
Breast & Thyroid Surgery, One Week, October 22
Gallbladder Surgery, 3 days, October 29
Fractures & Traumatic Surgery, Two Weeks, October 15

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, October 22
Vaginal Approach to Pelvic Surgery, One Week, October 15
General and Surgical Obstetrics, Two Weeks, November 5

MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, October 8
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Many refrain from bringing up the subject out of a sincere respect for their doctor, supposing it somehow unbecoming to talk to him about money. Many professional societies are now trying to clear up this misconception. For example, you may have noticed a significant plaque which hangs in thousands of physicians' waiting rooms. It says:

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Mobile Enrollment Unit Begins Operation

Blue Shield's latest public relations and sales innovation began operation on a trial basis during the first week of October. The mobile enrollment office pictured above began a series of test enrollment stops at Spring Green, Argyle, and Blanchardville.

The unit, towed by a station wagon, will eventually tour the small towns and rural areas of Wisconsin as a traveling advertisement, a rolling public relations office, and a mobile sales office for Blue Shield and Blue Cross protection on an individual basis. Heretofore, virtually the only method by which an individual family could enroll in Blue Shield and Blue Cross was to send a request for an application to the enrolling and billing office in Milwaukee. Only a few thousand of the more than 300,000 persons covered by Wisconsin Physicians Service now hold the individual (nongroup) contracts.

The mobile office will be accompanied by appropriate newspaper, radio, and direct mail publicity. A sales representative will be on duty in the trailer during the hours that it is open in each town. He will be able to discuss Blue Shield and Blue Cross coverage with potential subscribers as well as those who already have the protection. An advance representative will precede him in each community to contact physicians, hospitals, civic officials, and newsmen.

The trailer is owned by and operated under the direction of Wisconsin Physicians Service, although Blue Cross is sharing a portion of its operational expense.

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OBITUARIES

Dr. J. R. Harvey, 74, a Footville physician for 42 years died July 19 at a Janesville hospital after a long illness.

Doctor Harvey was born in 1882 in Eagle, Richland County. He received his medical degree from Milwaukee Medical College, now a part of Marquette University School of Medicine. He served a one-year internship at Milwaukee County General Hospital.

In 1912 he located in Footville and, except for three years served in the army medical corps during World War I, he remained in that area until his retirement in 1954.

At a testimonial dinner given Doctor Harvey in 1954, he was recognized as the ideal type of family physician by the State Medical Society, which presented him with an engraved silver plaque.

He is survived by an adopted son, John M. Langdon, Elmhurst, Illinois; two grandchildren; and two sisters, Mrs. James Miller, Eau Claire, and Miss Lillian Harvey of Excelsior.

Dr. S. J. Francois died July 23 at his home at the age of 65 years.

He established his practice in New Glarus in 1916, immediately after he graduated from Marquette University School of Medicine. On July 5 of this year, he marked his fortieth year as a physician there.

In 1934 Doctor Francois did postgraduate work in general medicine and in the field of eye, ear, nose, and throat in Paris and Vienna.

He was a member of the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was on the staff of the St. Clare Hospital, Monroe.

Survivors include his wife, Marie; two aunts; and two uncles.

Dr. A. A. Solberg, La Crosse, died August 27 at a La Crosse hospital after an illness of several years.

Doctor Solberg was born in Norway in 1884. He came to the United States with his parents as a young boy and settled in Michigan. After attending schools in Ishpeming, Michigan, he enrolled at the Chicago College of Medicine and Surgery, from which he received his medical degree.

He had practiced medicine and surgery for 35 years in Wisconsin when he retired because of ill health.

Survivors include his wife, Olga; two daughters, Kathryn Jean of La Crosse, and Captain Anna Margaret Munson of Tokyo, Japan.

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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YOUR NAME AND ADDRESS

Dr. J. W. Livingstone, a Hudson physician for the past 40 years, died July 25 at the age of 75.

Doctor Livingstone was born in 1881 at Ann Arbor, Michigan. He attended the University of Illinois Medical School, graduating in 1905. After serving his internship at St. Joseph's Hospital in St. Paul, he did postgraduate work in Boston and at the University of Vienna, Austria.

He began the practice of medicine in North Dakota and in 1914 moved to Hudson, where he remained until his death.

During his medical career, Doctor Livingstone served as surgeon for the Chicago, St. Paul, Minneapolis, and Omaha Railroad and as physician for the Omaha Benefit for 36 years. He was a member and past president of the Pierce-St. Croix County Medical Society, a member of the State Medical Society of Wisconsin and its 50-year club, and a member of the American Medical Association.

There are no survivors.

Dr. H. A. Shearer, Beloit, died July 27 at a Madison hospital at the age of 62.

Doctor Shearer was born in 1894 at Fennimore. In 1922 he graduated from Marquette University School of Medicine, after which he practiced for a short time in Edgerton. Later he took special training in Vienna in eye, ear, nose, and throat work. He began practice in Beloit in 1930 and remained there until his retirement in 1950.

He was a member of the State Medical Society of Wisconsin, the Rock County Medical Society, and the American Medical Association.

Surviving are his wife; a son, John, of Texas; and two sisters and two brothers.

Dr. L. E. Rauchschwalbe, Oconto Falls, died August 11 at the age of 53.

He was born in 1903 at Milwaukee and attended Loyola University School of Medicine in Chicago, from which he was graduated in 1930. He served his internship at Methodist Hospital, Madison, from 1929 to 1930.

Prior to establishing his practice at Oconto Falls in 1943, Doctor Rauchschwalbe had practiced at Mendota State Hospital in Madison and also in Milwaukee and Wauzeka.

He was a member of the Oconto County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his wife, Dorothea; three brothers, Roland, Frank, and Ernest, all of Milwaukee; and a sister, Mrs. Joseph Baer, Milwaukee.

Dr. R. T. Hansen, 63, health commissioner of Wauwatosa for 14 years before his retirement in 1948, died August 21 at his farm home near Hartland.

Doctor Hansen was born in Milwaukee and received his medical degree from Marquette University in 1918. He began practicing medicine in Wauwatosa

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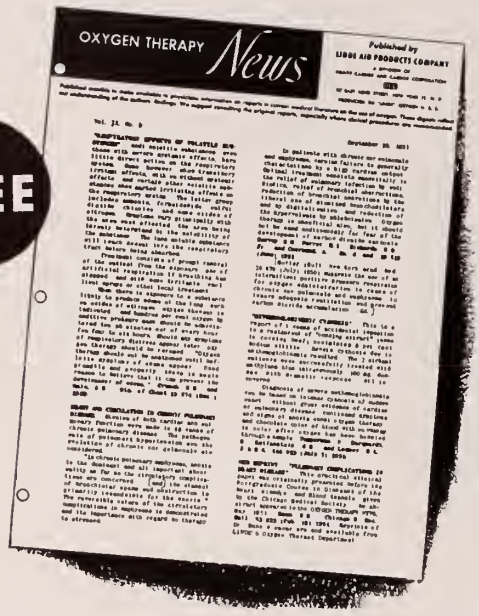

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after his graduation and continued for 30 years. During that time, he was on the staffs of the Johnston Emergency and Mount Sinai hospitals. He had served as chief of staff at Johnston Hospital.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

His wife, Elsie; a daughter, Mrs. Janet Bate, Pewaukee; and a son, Roy T., Jr., of Hartland, are the survivors.

Dr. M. J. Donohue of Antigo died August 24 at his home at the age of 82.

Doctor Donohue was born in Sheboygan in 1874 and later moved to Antigo with his parents. He was graduated from Northwestern University in 1898, after which he practiced medicine in Clintonville for a short time.

In 1899 Doctor Donohue moved to Antigo, where he practiced for 57 years. He became a member of the state society's 50-year club in 1948. He was instrumental in the work leading to the establishment of the Langlade County Memorial Hospital and was chief of staff at the hospital from the time it started until his death.

He was a member of the Langlade County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Besides his wife, two children, Eugene, of Sheboygan, and Betsy of Madison, survive.

Dr. Edward M. Rice, 83-year-old retired Milwaukee physician, died August 26 at his home in Wauwatosa after a short illness.

Doctor Rice was born in rural Brown County, Wisconsin. Before entering medical college, he was graduated from the law school of the University of Wisconsin. He practiced law for several months in Green Bay, after which he attended the medical school of Marquette University, from which he was graduated in 1903.

He was in general practice in Kewaunee for 10 years. After taking specialized training in the field of eye, ear, nose, and throat, he joined his brother, the late Dr. R. H. Rice, who was an E.E.N.T. specialist in Milwaukee. Upon his retirement in 1953, Doctor Rice had spent 40 years as a specialist in eye, ear, nose, and throat diseases.

He was a member of the National Ophthalmic Society; an honorary member of the staff at St. Luke's Hospital, Milwaukee; an honorary member of the former Marquette Annex E.E.N.T. Hospital; and a member of the Half-Century Club of the University of Wisconsin. He was also a member of the Medical Society of Milwaukee County, the State Medical Society and its 50-year club, and the American Medical Association.

Surviving are his wife, Estelle, and a daughter, Mrs. Margaret E. Korbish, of Gardena, California.

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Dr. J. H. Frank, 86, died at his home in Neillsville on August 29.

Doctor Frank was born in 1869. He received his medical degree from the Milwaukee County Physicians and Surgeons College, now part of Marquette University at Milwaukee.

He opened his medical practice in Antigo in 1889. In 1900 he located at Neillsville, where he served for 56 years.

His wife and two sons, Alonzo, Waukesha, and Dr. H. A. Frank, Neillsville, survive.

Dr. G. C. Devine of Ontario died August 30 in a Hillsboro hospital at the age of 81 years.

Doctor Devine was born at Oregon, Wisconsin, and attended Rush Medical College, Chicago. He had been in general practice in Wisconsin since his graduation from medical school.

He is survived by his wife; one son, George W., Waukesha; and one brother in California.

Dr. A. T. Shearer, Edgerton physician since 1910, died September 3 at an Edgerton hospital after a long illness. Born in Fennimore in 1882, he was 74 years of age at the time of his death.

He was graduated from the University of Illinois Medical School in 1907 and interned and took advanced training at Augustana Hospital in Chicago.

He was founder of the Shearer, Sumner, and Falk Clinic in Edgerton. He had served as a surgeon for the Milwaukee Railroad.

Doctor Shearer was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife; a daughter, Mrs. V. S. Falk, Jr., Edgerton; and a brother and two sisters.

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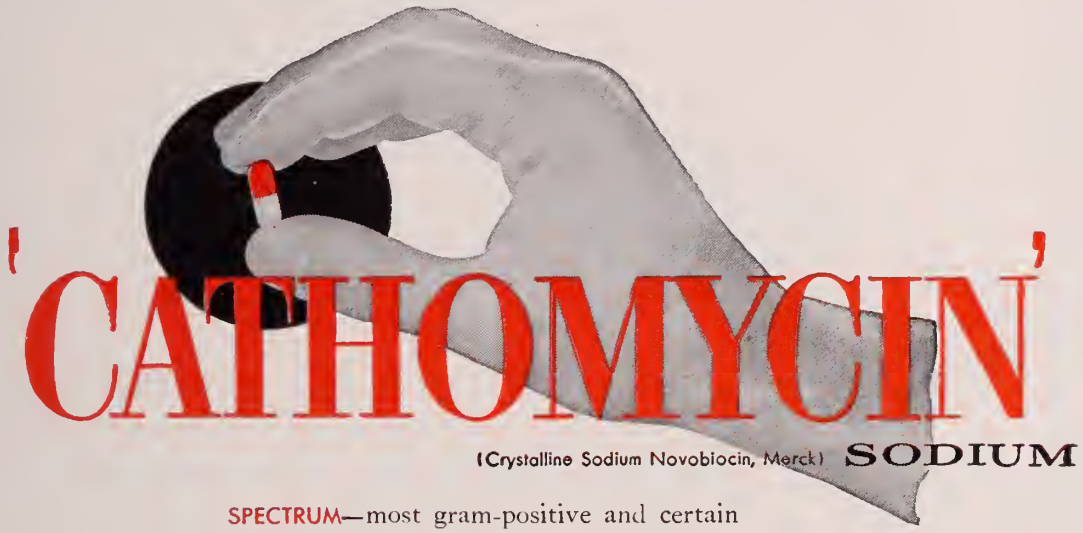

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General Electric ____ 1063
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Hotel Schroeder ____ 1132
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Hurley X-Ray Company ____ 1132

Keeley Institute ____ 1132
Kennedy–Mansfield ____ 1128
Knox Gelatine ____ 1138

Lakeside Laboratories ____ 1050, 1129, 1146
Lederle Laboratories ____ 1059, 1092, 1093, 1148
Lilly, Eli and Company ____ 1072
Linde Air Products ____ 1140

Mallard, Incorporated ____ 1144
Mallatt Pharmacy ____ 1128
Mather Pharmacy ____ 1128
Medical Protective Company ____ 1144
Merck, Sharp and Dohme ____ 1046, 1047, 1143
Milwaukee Sanitarium Foundation, Inc. ____ 1152

New York Polyclinic ____ 1142

Orthopedic Appliance Company ____ 1144

Parke, Davis and Company ____ 1042, 1043, 1134, 1135
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc. ____ 1052, 1053, 1124
Physicians Casualty Association ____ 1133
Pogue, Mary, School, Inc. ____ 1137
Professional Business Service ____ 1115
Provident Life and Accident Insurance Company ____ 1109

Quincy X-Ray and Radium Laboratories ____ 1137

Rennebohm's ____ 1128
Riker Laboratories, Inc. ____ 1123
Rogers Memorial Sanitarium ____ 1152

Sacred Heart Sanitarium ____ 1109
St. Croixdale Sanitarium ____ 1045
Schering Corporation ____ 1056, 1057, 1066, 1067, 1070, 1071
Schieffelin and Company ____ 1146
Searle, G. D. and Company ____ 1107
Shorewood Hospital Sanitarium ____ 1129
Smith, Kline & French Laboratories ____ 1065
Squibb, E. R., & Sons, Div. of Mathieson Chemical Corp. ____ 1048

Time Insurance Company ____ 1113

Upjohn ____ 1121

Wallace Laboratories ____ 1049
Wine Advisory Board ____ 1058
Winthrop Laboratories, Inc. ____ 1126, 1142
Wisconsin Neurological Foundation ____ 1125
Wyeth ____ 1055, 1061, 1119, 1147
Year Book Publishers ____ 1051

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J. C. Griffith, Milwaukee, 1957
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Alternates

L. O. Simenstad, Osceola, 1958
E. L. Bernhart, Milwaukee, 1958
R. E. Galasinski, Milwaukee, 1957
C. E. Koepp, Marinette, 1957

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. E. Kreher Ashland	J. M. Jauquet 220 7th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe Rice Lake	F. H. Goetsch Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	Louis Milson 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	Kenneth Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	B. J. Haines Cadott	Second Tuesday
Clark	J. W. Koch Colby	T. N. Thompson Neillsville	
Columbia–Marquette–Adams	H. Y. Fredrick Box 253 Westfield	F. W. Gissal 132 Washington Ave. Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	W. S. Cusick Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. S. Gearhart 621 S. Park Madison	T. V. Geppert 113 N. Carroll Madison	Second Tuesday Sept. through June
Dodge	R. I. Bender 147 Front Beaver Dam	M. E. Royce Mayville	Last Thursday*
Douglas	Conrad Giesen 1514 Ogden Superior	J. McGinnis 2231 E. Fifth Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	R. A. Buckley 131 S. Barstow Eau Claire	G. E. Wahl 616 E. Grand Eau Claire	Last Monday
Fond du Lac	Josephine N. Pallin 73 W. 12th Fond du Lac	Howard Mauthe St. Agnes Hospital Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	Charles Shields Fennimore	H. W. Carey Lancaster	Last Thursday, March, June, Sept., and Nov.
Green	F. J. Bongiorno Albany	D. E. Mings Monroe Clinic Monroe	
Green Lake–Waushara	A. J. Wiesender Berlin	G. C. Stone 124 N. Wisconsin Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	R. W. Quandt 1108 Main Jefferson	C. E. Quandt 804 Lincoln Ave. Jefferson	Third Thursday*

* Except June, July, and August

** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. T. Garren 6124 Sheridan Rd. Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	A. A. Cook 1707 Main La Crosse	J. L. Jaeck 1836 S. Ave. La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	R. E. Hunter Argyle	Last Tuesday
Langlade	W. P. Curran Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah Merrill	
Manitowoc	H. J. Belson 904 S. Eighth Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	E. B. Brick 501½ Third Wausau	J. V. Flannery 404 Third Wausau	
Marinette–Florence	R. J. Rogers Oconto	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	J. W. Fons Southgate 3333 South 27th Milwaukee	D. W. Ovitt 3300 W. Wisconsin Ave. Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	A. F. Slaney Oconto	F. E. Zantow Oconto	
Oneida–Vilas	T. M. Haug 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	A. C. Taylor 103 W. College Appleton	H. T. Gross 103 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	Frank Springer Elmwood	P. H. Gutzler River Falls	Third Tuesday
Polk	F. L. Whitlark Amery	L. J. Weller Osceola	Third Thursday 7 p.m.
Portage	H. A. Anderson Stevens Point	W. A. Gramowski 319½ Main Stevens Point	
Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	Louis E. Fazen, Jr. 725 Main Racine	F. M. Hilpert 312 Seventh Racine	Third Thursday
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Vernon	H. E. Oppert Viroqua	DeVerne W. Vig Viroqua	Last Wednesday
Walworth	G. A. Smiley Delavan	H. J. Werbel Delavan	Second Thursday*
Washington–Ozaukee	Kenneth Pelant Grafton	J. F. Walsh 125 E. Main Port Washington	Fourth Thursday
Waukesha	Albert Rogers Box 307 Oconomowoc	Phillip Wilkinson 618 W. La Belle Ave. Oconomowoc	
Waupaca	W. G. Arnold Clintonville	G. P. Dernbach New London	
Winnebago	J. T. Petersik State Hospital Winnebago	G. B. Hildebrand 216½ Main Menasha	First Thursday
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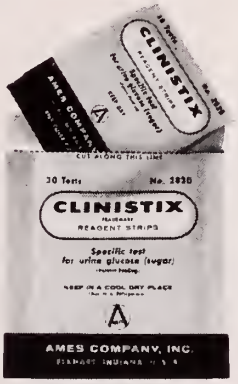

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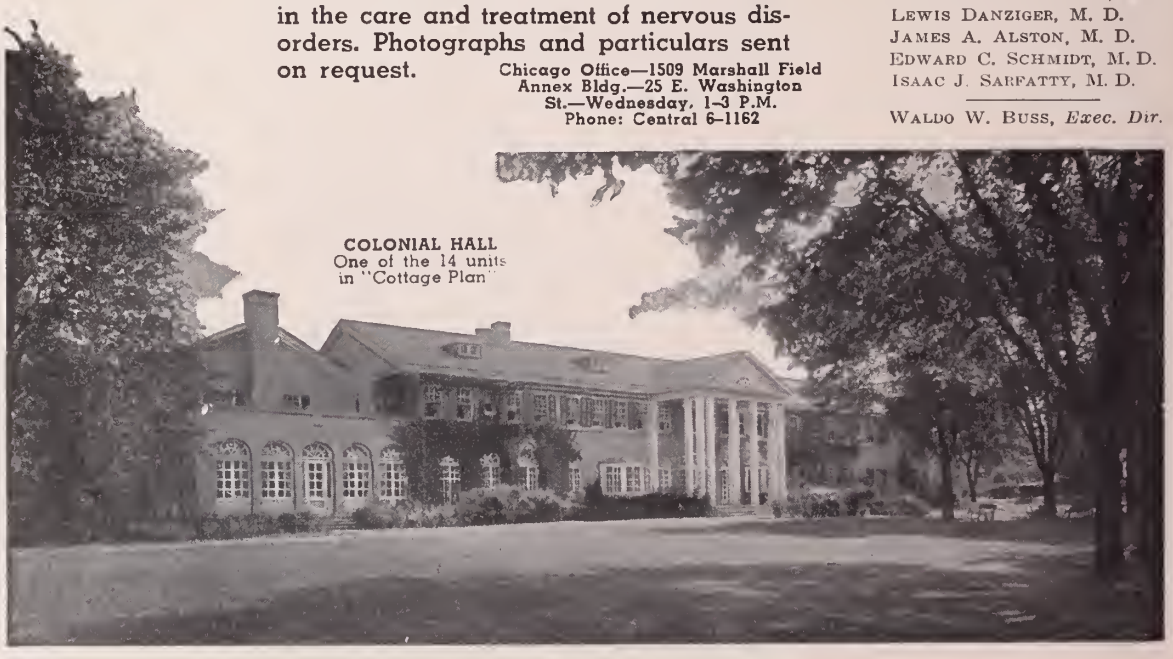

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
A Study of the Control of the Hepatitis–Transmitting Potential of Plasma, by Ned G. Maxwell, M. D.	1183
Zoonoses—A Serious Medical Problem, by William S. Middleton, M. D.	1189
Carcinoma of the Thyroid, by R. L. MacCornack, Jr., M. D., F. Glassy, M. D., and R. H. Segnitz, M. D.	1197
Doctors Plan War on Uterine Cancer	1202
Case Report of a Fatal Infection With Bacteroides Fragilis, by Ernst M. Froehlich, M. D., and Edmund W. Schruempf, M. D.	1203
Comments on Treatment	1208
Clinicopathologic Conference	1212
Bowel Obstruction, Unusual Manifestation of Weber–Christian Disease, by Marvin E. Sattler, M. D., and A. I. Greenberg, M. D.	1219

MISCELLANY

	Page
Gleanings from the Section on Medical History	1223
Society Proceedings	1228
News Items and Personals	1230
Third and Twelfth Districts News	1232
Society Records	1233
Obituaries	1234
The Journal Bookshelf	1264
Facts About Wisconsin Physicians Service	1266
Physicians' Exchange	1268
Index to Advertisers	1272
List of Officers and Scheduled Meetings of County Medical Societies	1274

EDITORIALS

The President's Page	1224
Thoughts on Rural Health	1226

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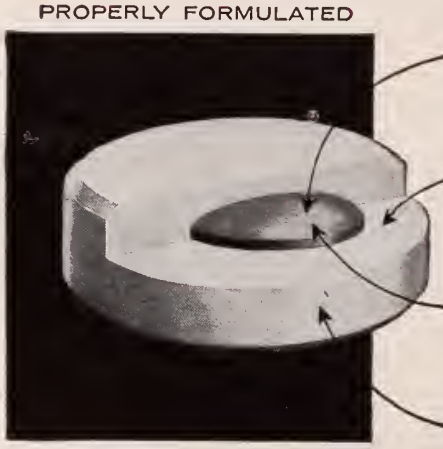

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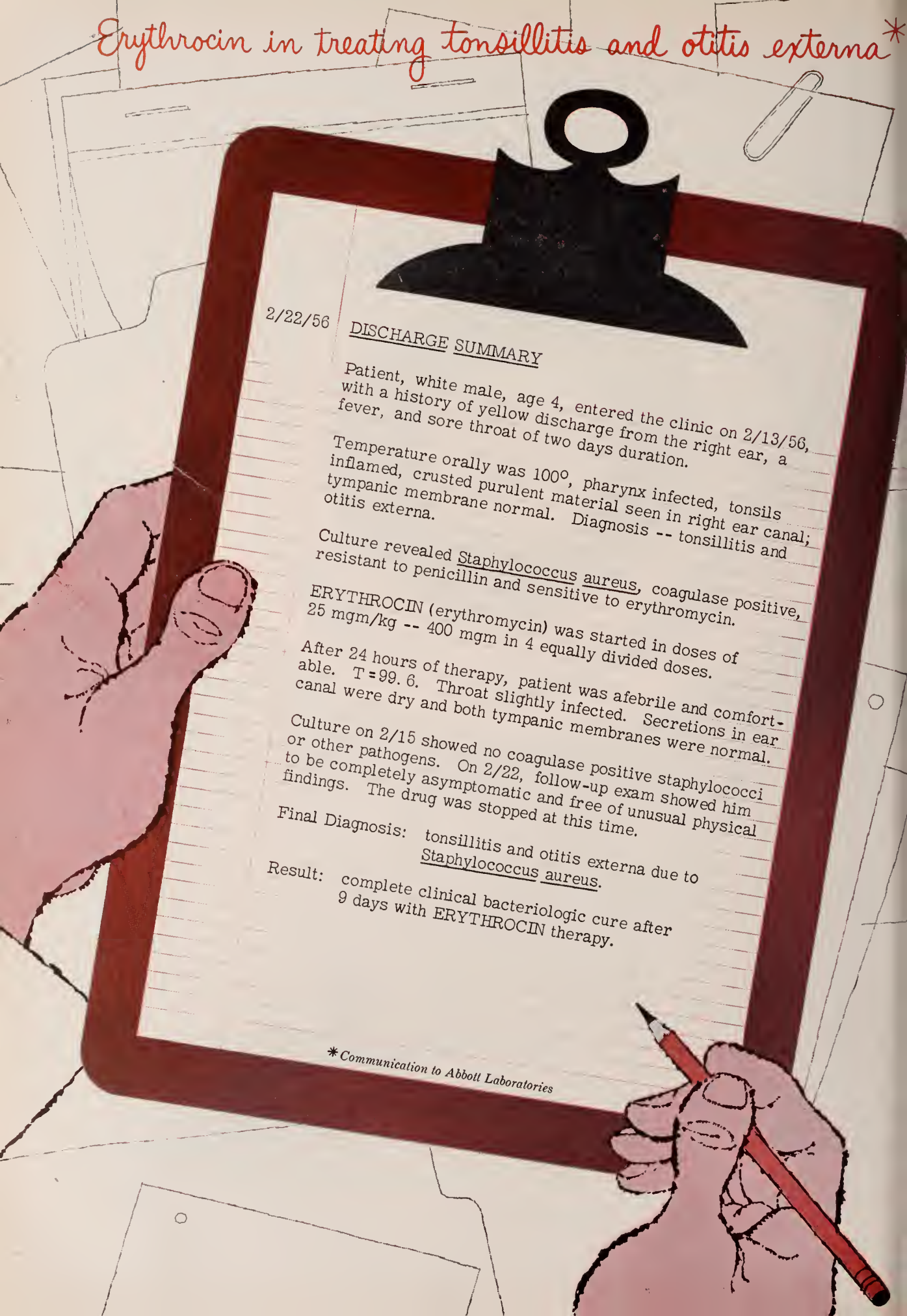

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DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
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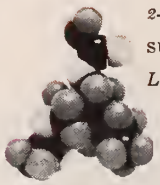

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The above excerpts are taken from the brochure "Uses of Wine in Medical Practice" which describes the results of recent laboratory and clinical research on the medical attributes of wine. Herein are reported the latest findings on the value of wine as a stimulant to flagging appetite, as an aid to digestion, as a vasodilator, as a daytime and night-time sedative.

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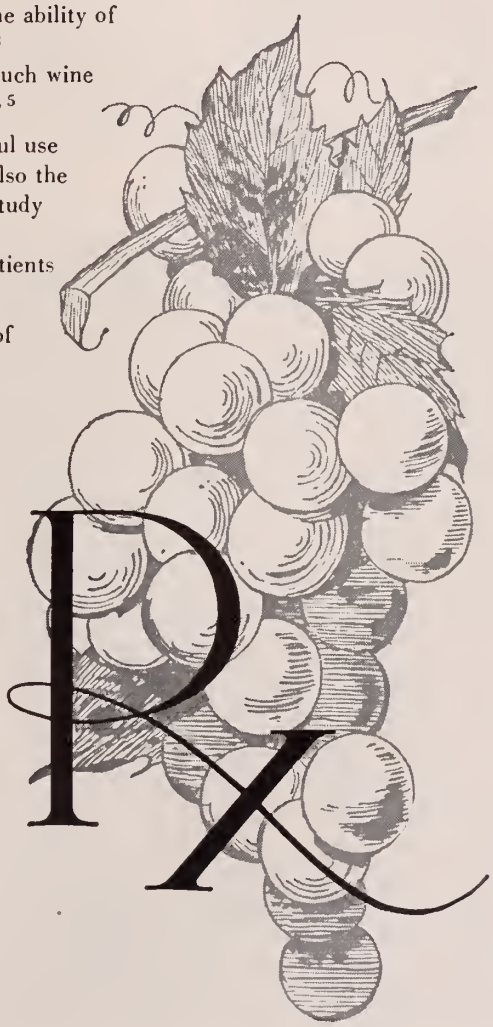
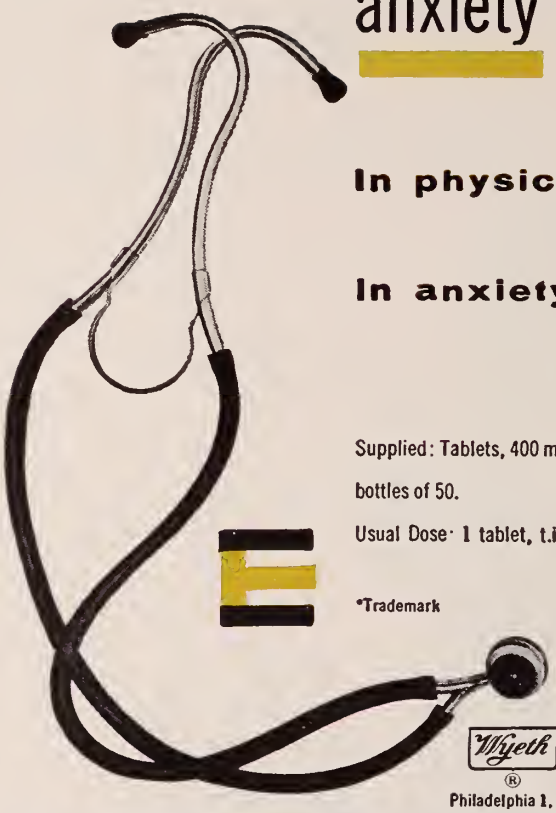


1. Margulies, N.R.; Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:1 (Jan.) 1950.
2. Irvin, D.L.; Ahokas, A.J., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:97 (Oct.) 1950.
3. Goetzl, F.R.: Permanente Found. M. Bull. **8**:72 (April) 1950.
4. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **9**:119 (Oct.) 1951.
5. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. **20**:17 (Jan.) 1953.
6. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

anxiety is part of every illness



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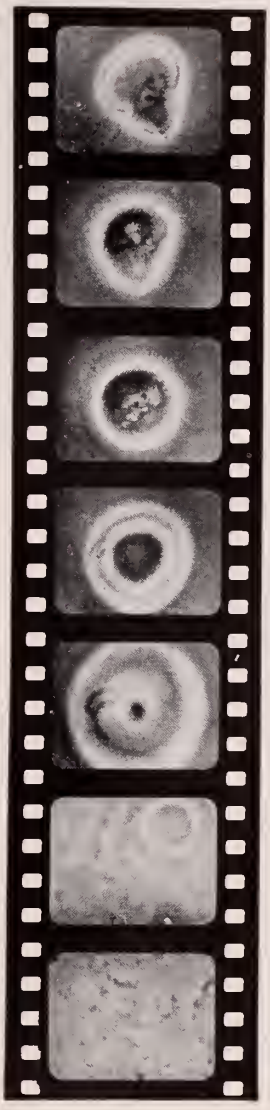

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4 sec. COMPLEXES
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References: 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. *168*:563 (Sept.) 1955.

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1. Ralli, E. P., and Dumm, M. E.: The Hormonal Control of Metabolism, in Wohl, M. G.: Modern Nutrition in Health and Disease, Philadelphia, Lea and Febiger, 1955, pp. 57-74.
2. McHenry, E. W.: Nutrition and Endocrine Function, Borden's Review of Nutrition Research, *16*:17 (Mar.-Apr.) 1955.
3. Ershoff, B. H.: Conditioning Factors in Nutritional Disease, Physiol. Rev. *28*:107 (Jan.) 1948.
4. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, University of Minnesota Press, 1950.
5. Samuels, L. T.: Progress in Clinical Endocrinology, New York, Grune and Stratton, 1950, p. 509.

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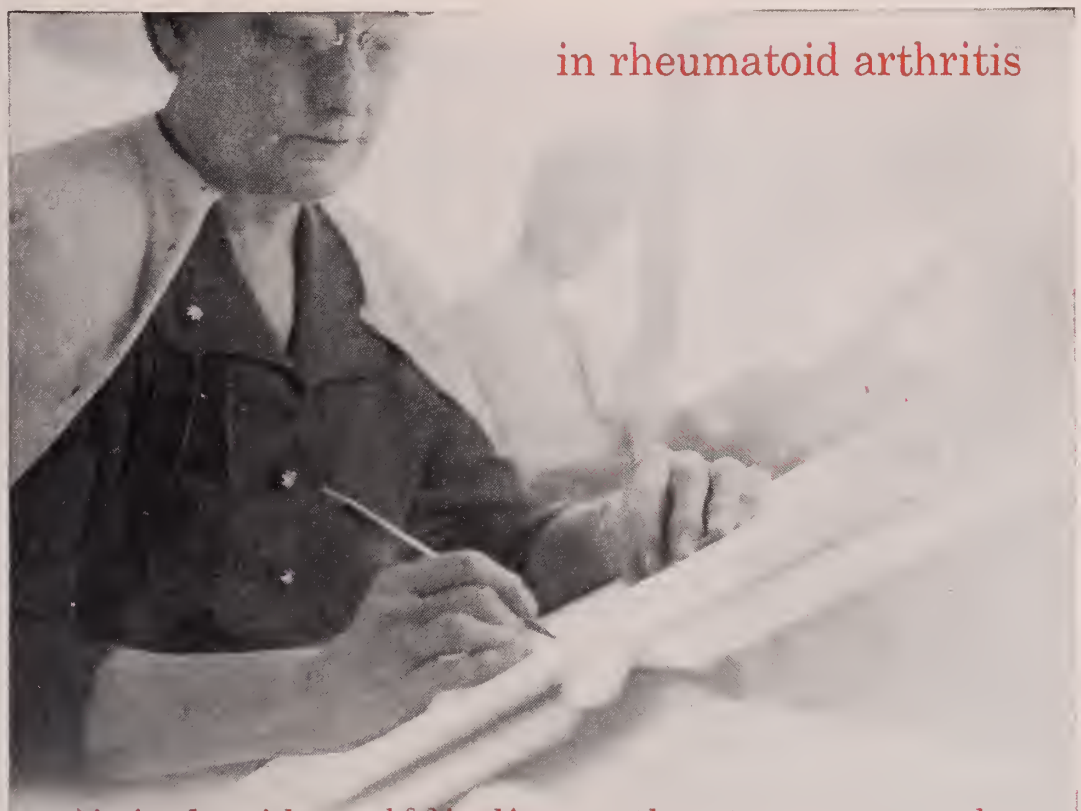

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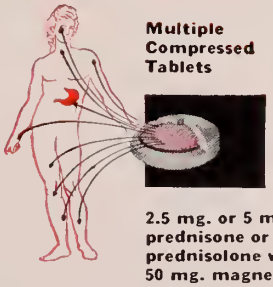

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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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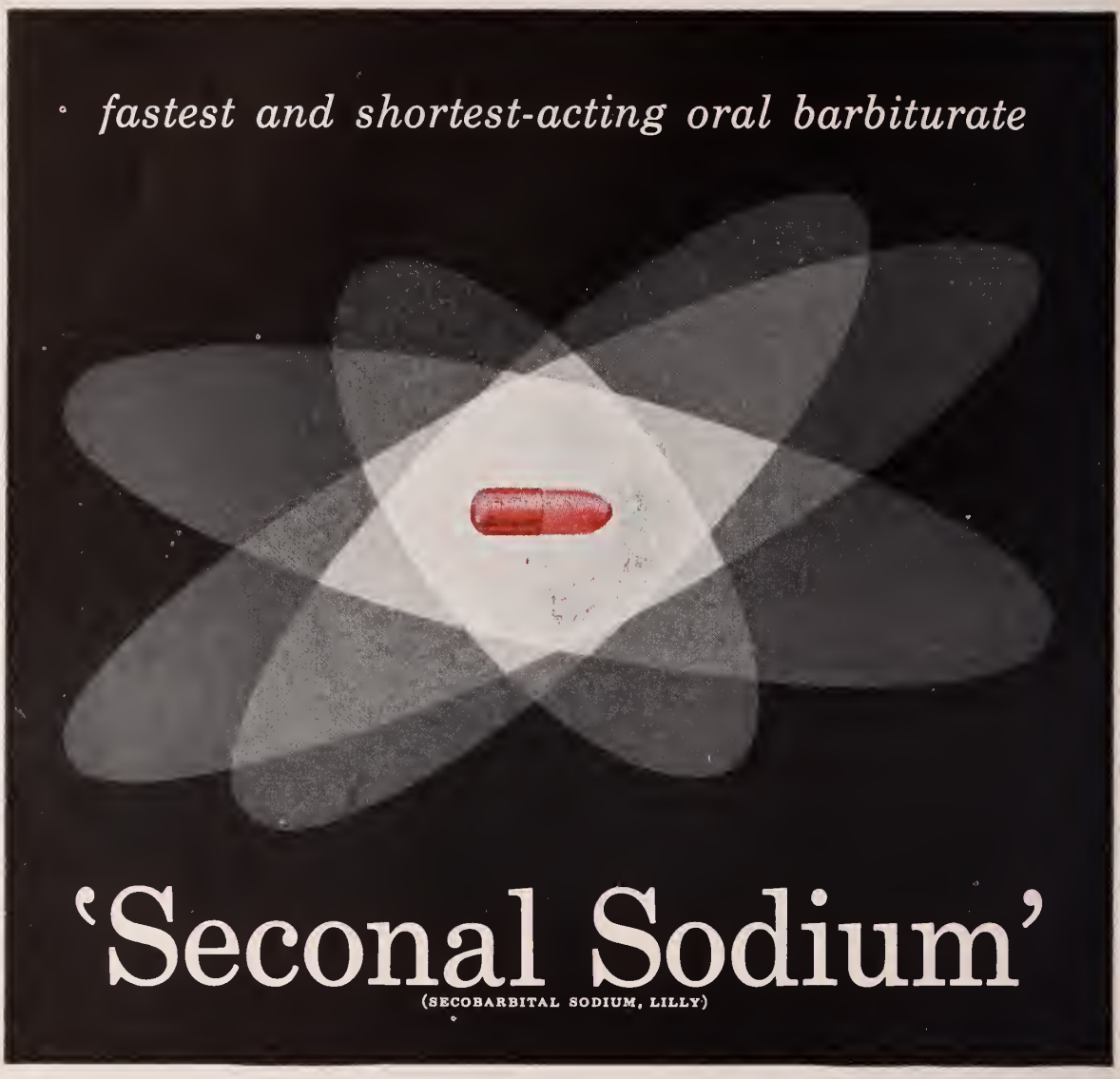

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Volume 55 NOVEMBER 1956 Number 11

A Study of the Control of the Hepatitis-Transmitting Potential of Plasma

By NED G. MAXWELL, M. D.
Milwaukee

INTRODUCTION

BLOOD banks deal with a perishable product. The maximum period of usefulness for whole blood is 21 days. In order to meet the demands of modern surgery and medicine, all groups and types must be kept in relatively large supply for use at a moment's notice. This situation creates the problem of outdating a certain per cent of "old" blood. During World War II and the Korean conflict, all the available "old" blood and even "fresh" blood, when possible, was converted to plasma. During these periods the serious complication of homologous serum hepatitis became apparent. The necessity to prevent this complication is self-evident.

Plasma continues to be the most nearly perfect emergency blood-volume expander. Many authors show its value as a protein supplement in chronic illnesses.[1-4] Further refinement of plasma, such as fractionation to albumin, even though it removes the risk of serum hepatitis,[5] substantially increases the cost of the final product.

Artificial plasma substitutes have been developed. These products, as their use increases, are losing value because of interference with hemostasis,[6] interference with blood typing due to rouleaux,[7] or deposits of foreign material in the tissues.[8]

In dealing with the virus hepatitis transmitting potential of plasma, consideration must be given to the method of preparing and preserving this component of blood. There is probably one carrier of viral hepatitis among every 200 to 800 normal donors.[9-10] In the large-scale manufacture of plasma, large numbers of donors (over 1,000) are represented in a single pool. Under these circumstances at least one donor in each pool may be a carrier of hepatitis virus. The plasma is freeze-dried; this may preserve the virus for transmission to the recipient. The incidence of hepatitis with this type of large-pool plasma varies from 4.15% to 22%.[11-14]

REPORT OF STUDY

In 1953 a study was designed to follow all recipients of plasma prepared in different manners. The different methods of preparation have been used to classify and compare the phases of this study. The cases were selected according to the blood bank records of recipients of plasma who did not have blood transfusions. In the five-year period of study, 1948 to 1952, there were 4,839 units of plasma dispensed in 32 hospitals in four counties. This study was done in retrospect and, therefore, the results are dependent upon physicians' records; hospital records; and, when necessary, patients' memories. The value of this type of study is in the employment of full therapeutic doses of the test material. There are no means at present of determining anicteric or subclinical cases of hepatitis in large survey studies of this type.

The presence of the virus of hepatitis in our blood donors was confirmed during the study. A survey made in one institution from the years 1946 to 1954 revealed 10 cases of blood-transmitted hepatitis resulting from 14,686 whole blood transfusions. The incidence must be considered too low (.07%) when compared to the figures reported in the literature.[11,13,15] The reason the follow-up showed a tenfold loss was that only the cases rehospitalized in the same hospital could be

TABLE 1—*Persons Studied Who Received Plasma Treated by Several Methods*

Type of Plasma Treatment	Negative	Liver Disease Unclassified	Serum Hepatitis	Total
Small pool, less than six months' room-temperature, liquid storage. October, 1948—April, 1949	133	3	0	136
Small pool, more than six months' room-temperature, liquid storage. April, 1949—March, 1950	127	5	0	132
Moderate pool, more than six months' room-temperature, liquid storage with ultraviolot radiation. April, 1950—March, 1952	265	7	0	272
Total	525	15	0	540

studied. There was no specific follow-up made on each patient that received blood. However, this observation demonstrates that virus hepatitis is indigenous in the blood supply in this area. The plasma was prepared from outdated ACD blood* from the same source, and some incidence of hepatitis was to be expected in the recipients.

Classification of Patients

The classification of patients was made from the histories. Each attending physician was contacted by letter. He certified that he had had the patient under his care for the six months following the transfusion. A definite statement concerning liver disease had to be made. If either requirement was not fulfilled, we sent the patient, after obtaining permission from his physician, a letter questioning him as to liver disease, jaundice, acholic stools, dark urine, or gastrointestinal complaints during the six-month period following the transfusion. Telephone calls were needed only occasionally, and no personal visits were made. These patients fell into five groups:

1. **Negative:** Patients who showed no signs or symptoms of any liver disease for the six months following the transfusion. There were no known liver function studies done in these cases. **Conclusion:** Clinical or icteric hepatitis did not develop (table 1).

2. **Died:** Patients who died either in less than two weeks or from two weeks to six months after the plasma transfusion in whom there was no available evidence of clinical, chemical, or morphologic liver disease (table 2).

3. **Unlocated:** Patients who had no forwarding address (table 2).

4. **Liver Disease, Unclassified:** Patients who died with, or had, liver disease probably not due to viral hepatitis (table 1).

5. **Positive:** Patients in whom icteric hepatitis developed during the six months after transfusion.

First Phase of Study—Small Pools

The first study was of plasma prepared between October, 1948, and April, 1949. The plasma was removed from the outdated ACD blood. Plasma of from seven to ten donors was pooled, cultured, and bottled. The units were then ready for distribution. The majority of these units were used with less than six months of liquid, room-temperature storage. Two hundred sixty-five patients were traced. There were 133 negative reports, 60 patients died, and 69 could not be located.

Seven units of plasma were given to 3 patients who were rated as Liver Disease, Unclassified:

Case A.*—The patient was given one unit of plasma. He had a small bowel obstruction and was operated upon twice in December, 1948. By Jan. 24, 1949, he was severely dehydrated with an icterus index of 21.4. This evidence of liver dysfunction was not

* ACD is the acid-citrate-dextrose solution present in the blood bottle before bleeding. It acts as an anticoagulant and nutrient solution. There are two types of ACD solution. Solution A contains tri-sodium citrate 2.20 gm., citric acid .80 gm., dextrose 2.45 gm., and water for injection q.s. 100 cc. For 480 cc. whole blood, 72 cc. of solution A is used. Solution B contains tri-sodium citrate 1.32 gm., citric acid .48 gm., dextrose 1.47 gm., and water for injection q.s. 100 cc. For 480 cc. whole blood, 120 cc. of solution B is used.

* To avoid confusion the cases discussed in the article are lettered A to O.

TABLE 2—*Inconclusive Results of Questionnaire Sent to Attending Physicians on the Recipients of Plasma*

	Group 1 October, 1948 to April, 1949	Group 2 April, 1949 to March, 1950	Group 3 April, 1950 to March, 1952	Total
Available for study	265	235	538	1,038
Died of causes other than hepatitis during the six-month study period	60 (23%)	51 (22%)	151 (28%)	262 (25%)
Recipients not located	69 (26%)	52 (22%)	115 (21%)	236 (23%)
Total	129 (49%)	103 (44%)	266 (49%)	498 (48%)

considered due to hepatitis by the attending physicians. He later had multiple readmissions for acute and chronic alcoholism, alcoholic gastritis, and delirium tremens.

Case B.—The patient received four units of plasma in January, 1949. The diagnosis before the plasma was given was cirrhosis and nephritis. He died the same month in uremic coma.

Case C.—The patient had poliomyelitis in August, 1949. She was given one unit of plasma from two pools (pools 231 and 243). During her convalescence she developed a mild anemia and was told her skin was "yellowish." She remembers no urinary or stool color changes and lost no time from her usual occupation.

Case C is the most suspicious one in the study. This patient had moved out of the state and so communication was by telephone. From Pool 231 there were 4 other patients who received the same pool plasma: 2 Negative, 1 Died and 1 Unlocated. From Pool 243 there were 2 other recipients, both negative. In view of the fact that not all recipients develop hepatitis from known icterogenic plasma,[5] the 2 negative cases from each pool do not prove that these pools were safe. Assuming a 50% chance of infection statistically, these two negatives would occur by chance one out of four times.

The first factor in controlling hepatitis transmitted by plasma is demonstrated in this study period. The plasma units were prepared from small pools. There were seven to ten donors represented in each pool. The hepatitis risk is then comparable to that of blood transfusions. The Ministry of Health in England[15] reported that with small-pool (less than 80 donors), freeze-dried plasma with or without blood, the incidence of serum hepatitis was .12%. With blood transfusions alone, the incidence was .16%. Lehane[13] reports an incidence of serum hepatitis of 11.9% with large-pool plasma (300 or more donors) and 1.3% serum hepatitis with small-pool plasma (not more than 10 donors).

Second Phase—Six Months' Liquid, Room-Temperature Storage

The second study was of plasma prepared between April, 1949, and March, 1950. The pools remained small, with seven to ten donors represented, but all units were stored in liquid state and at room temperature for more than six months. There were 235 patients traced; 127 were Negative, 51 Died, 52 were Unlocated, and there were 5 Liver Disease, Unclassified.

Five patients with Liver Disease, Unclassified, received 31 units of plasma:

Case D.—The patient died one month after plasma of sepsis complicating the primary disease, thromboangiitis obliterans with amputation. All systems, including the liver, were involved.

Case E.—The patient received one unit of plasma in January, 1950. He had a gallbladder attack two and one-half months later. There was no other evidence of hepatitis.

Case F.—The patient had a history of cirrhosis and received 14 units of plasma between November, 1949, and January, 1950. He died Jan. 6, 1950. Postmortem examination revealed acute interstitial nephritis and chronic active cirrhosis of the liver. The pathologist was unable to recognize anything resembling viral hepatitis.

Case G.—The patient was in intractable congestive heart failure and received 10 units of plasma during November and Decem-

ber, 1950. He developed, during this time, a large, tender liver, but this was considered due to the congestive failure.

Case H.—The patient received four units of plasma. He died four months later. Post mortem, the diagnosis was cirrhosis of the liver with no evidence of recent activity.

The second division of this study adds the second factor in reducing the incidence of serum hepatitis. All of the units given were stored in the liquid state at room temperature for six months or more. Allen[2,3] first pointed out in 1950 that liquid, room-temperature storage of plasma made the transmission of hepatitis very doubtful. This premise was tested by Murray,[16] who used known icterogenic plasma. He reported: "The fact that hepatitis developed in only one person out of the nineteen who received plasma stored at room temperature for six months suggests that the infectivity of such material must be low." The test dosage was 1 to 2 cc. Before storage this volume caused hepatitis in volunteers. In the same article Murray states: "It has been shown that materials that have appeared innocuous when administered in small doses (1 to 3 ml.) have produced hepatitis when given in the doses used clinically." For this reason clinical survey studies of the type reported here are necessary.

Third Phase—Ultraviolet Radiation

The latest study period was from April, 1950, to March, 1952. Processing was changed in two ways: the size of the pools was increased to contain plasma from 140 donors (range, 120 to 180), and the plasma was radiated with ultraviolet light. Each lot was cultured, radiated, bottled, cultured again, and stored for six months or more in the liquid state at room temperature. There were 538 patients traced. Of these there were 265 Negative, 151 Died, and 115 were Unlocated. There were 7 Liver Disease, Unclassified, that received 14 units of plasma.

Case I.—The patient had two units of plasma in December, 1951. He had an attack of gallbladder colic three months later. There was no evidence of intrahepatic disease.

Case J.—The patient had renal colic Aug. 12, 1952, and received one unit of plasma Aug. 14, 1952. By August 20 he had a high serum bilirubin level and died the next day. The liver showed chronic disease with changes compatible with uremia.

Case K.—The patient received one unit of plasma from Pool 25–51. He died one year after the plasma was administered, with a history of repeated episodes of jaundice. The diagnosis at death was diabetes mellitus, gallbladder disease, and alcoholism.

Case L.—The patient received two units of plasma from the same lot as the patient above, Pool 25–51. He died in two months of arteriosclerosis, hypertension, and cirrhosis.

Case M.—The patient received one unit of plasma. He had a diagnosis of mild regurgitation hepatitis due to stricture of the common duct. He has had no jaundice since surgery.

Case N.—The patient received two units of plasma. The attending physician states that liver disease was present before plasma administration, and there has been no increase in liver symptoms.

Case O.—The patient received five units of plasma. Before the plasma was given, she had a diagnosis of chronic passive congestion of the liver due to rheumatic heart disease in failure. The patient was clinically quite icteric when the plasma was given. She died during the fifth month post-transfusion.

Case J is included because of the evidence of liver disease developing suddenly after the plasma. There is no evidence in the literature of hepatitis developing in less than two weeks after a patient's receiving infected material.[6] There was no necrosis of the liver, and the architecture was well preserved.

Cases K and L were the only two cases of Liver Disease, Unclassified, occurring in the same pool (see table 3). From this pool, 25–51, there were three other recipients of plasma that did not develop hepatitis. Again assuming 50% case rate in exposed persons, then three negative cases would occur by chance only once in eight times.

In this third division the procedure of radiation was added. Pools were of moderate size, and the plasma was not used until at least six months' room-temperature, liquid storage was complete. Murray[17] stated in 1955: "In cases of hepatitis resulting from

TABLE 3—*Rate of Liver Disease, Unclassified, in Pools Arranged on the Basis of Occurrence of One or More Cases of Liver Disease Among the Recipients*

Occurrence of Liver Disease in Recipients	Pools Studied	Patients with Liver Disease Unclassified	Other Recipients Studied	Multiple Cases from Single Pool of Liver Disease Unclassified	Rate of Multiple Cases/100 Recipients
Present	35	15	79	1	1.2
Absent	297	0	461	0	0.0
Total	332	15	540	1	0.18

irradiated plasma there were longer incubation periods and in the aggregate there was milder illness as judged by maximum total serum bilirubin levels and duration of illness when compared with cases resulting from the unirradiated plasma."

Discussion

The virus of hepatitis has been shown to be present in some donors in spite of a carefully obtained history and blood chemical testing.[10] In view of this fact and the outdating of blood by modern blood banking procedures, a serious reconsideration of the values as well as the hazards of plasma must be made. The value of plasma in medicine today as a therapeutic tool is unquestioned. If the virus hepatitis transmitting potential can be controlled, plasma can return as a valuable tool available for use in a wide variety of clinical conditions.

In this study three factors were outlined in an effort to control the virus. The first study demonstrated that small pools reduce the icterogenic capacity of plasma even though the plasma is "fresh" (less than six months' room-temperature storage). If a larger number of small pools had been available for study, certainly one of these would have been icterogenic. The second section of the study added another controlling factor. The literature suggests that eradication of the virus of hepatitis results from six-month, room-temperature storage in the liquid state. Our clinical study would lend support to this concept. The last section added ultraviolet radiation and increased the donors represented in the pool to 140. Even though radiation alone has been shown to fail (not lethal to virus of hepatitis), the process has some effect on this hardy virus. In retrospect, 140-donor pool size may be too large; our method has been changed to include only 80 donors per pool.

At our present state of evaluation of icterogenic plasma, a product as safe as blood or even safer may be achieved by the combination of the three steps outlined. Further studies are in progress. All who deal with human fluids for parenteral use should be encouraged to follow the recipients as closely as possible. The most objective method for alerting the producer is through the physician responsible for the patient care. Simple but complete methods must be developed to enable the physician to notify the manufacturer of positive or suspicious results with any human biologic used as parenteral treatment. Only in this way will more accurate data be available from which it will be possible to make a critical evaluation.

Summary

A survey of 1,038 patients who received 1,796 units of plasma was reviewed for the incidence of hepatitis.

1. 50.6% of the total recipients developed no symptoms of liver disease classified by history.
2. 25.2% of the patients died of unrelated causes.
3. 22.7% of the patients could not be located.
4. 1.5% of the patients developed or had liver disease not considered to be viral hepatitis. Case reports are presented.
5. 0.0% of the patients developed hepatitis after plasma alone.

Reasons for the failure of transmission of hepatitis are considered to be:

1. Small to moderate sized pools (less than 200 donors).

2. Six months' liquid, room-temperature storage.
3. Ultraviolet radiation.

763 North 18th Street.

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REFERENCES

1. White, C. S., and Weinstein, J. J.: Blood Derivatives and Substitutes; Preparation, Storage, Administration and Clinical Results Including a Discussion of Shock, Etiology, Physiology, Pathology and Management, Baltimore, Williams and Wilkins Company, 1947.
2. Allen, J. G., Sykes, Carolyn, Enerson, D. M., and Moulder, P. V.: Homologous serum jaundice and its relationship to methods of plasma storage, J. Lab. & Clin. Med. 36:796–797 (Nov.) 1950.
3. Allen, J. G., and others: Homologous serum jaundice and its relation to methods of plasma storage, J.A.M.A. 144:1069–1074 (Nov. 25) 1950.
4. Allen, J. G., Enerson, D. M., Barron, E. S. G., and Sykes, Carolyn: Pooled plasma with little or no risk of homologous serum jaundice, J.A.M.A. 154:103–107 (Jan. 9) 1954.
5. Murray, R.: Viral hepatitis, Bull. New York Acad. Med. 31:341–358 (May) 1955.
6. Carbone, J. V., Furth, F. W., Scott, R., Jr., and Crosby, W. H.: Hemostatic defect associated with dextran infusion, Proc. Soc. Exper. Biol. & Med. 85:101–103 (Jan.) 1954.
7. Plasma volume expanders and blood typing, J.A.M.A. (Queries and Minor Notes Section) 154:1398 (April 17) 1954.
8. Gall, E. A., and others: Liver lesions following intravenous administration of polyvinyl pyrrolidone (PVP), Am. J. Clin. Path. 23:1187–1198 (Dec.) 1953.
9. Neefe, J. R.: Viral hepatitis, problems and progress to 1954, Am. J. Med. 16:710–728 (May) 1954.
10. Reinhold, J. G.: Chemical abnormalities in blood serum associated with carrier state of viral hepatitis, Clinical Chemistry 1:3–17 (Feb.) 1955.
11. Spurling, N., Shone, J., and Vaughan, J.: Incidence, incubation period, and symptomatology of homologous serum jaundice, Brit. M. J. 2:409–412 (Sept. 21) 1946.
12. Brightman, I. J., and Korns, R. F.: Homologous serum jaundice in recipients of pooled plasma, J.A.M.A. 135:268–272 (Oct. 4) 1947.
13. Lehane, D., Kwantes, C. M. S., Upward, M. G., and Thomson, D. R.: Homologous serum jaundice, Brit. M. J. 2:572–574 (Sept. 10) 1949.
14. Pooled plasma and jaundice (editorial), J.A.M.A. 154:146–147 (Jan. 9) 1954.
15. Preliminary communication: Homologous serum jaundice after transfusion of whole blood, dried small-pool plasma, dried irradiated plasma, and kaolin-treated filtered liquid plasma, Lancet 1:1328–1329 (June 26) 1954.
16. Murray, R., Ratner, F., Diefenbach, W. C. L., and Geller, H.: Effect of storage at room temperature on infectivity of icterogenic plasma, J.A.M.A. 155:13–15 (May 1) 1954.
17. Murray, R., and others: Effect of ultraviolet radiation on infectivity of icterogenic plasma, J.A.M.A. 157:8–14 (Jan. 1) 1955.

SYMPOSIUM ON IMMUNOLOGY

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T. N. Harris, M. D., Associate Professor of Immunology in Pediatrics, University of Pennsylvania
"Fundamentals of Immunology"

William B. Sherman, M. D., Associate Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons
"Applications of Immunology to Allergic Disease in Man"

Carl V. Moore, M. D., Professor and Head, Department of Medicine, Washington University School of Medicine
"Immunohematology"

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Zoonoses—A Serious Medical Problem*

By WILLIAM S. MIDDLETON, M. D.
Washington, D. C.

Introduction

WHEN man domesticated certain lower animals for his personal comfort and gain, he assumed the obvious hazard of sharing their diseases. To this risk was added the chance of contamination in seeking supplementation of his larder from the field and stream. The communicability of the infectious diseases makes this group of ailments especially important in this relation. The immediate contact with the mammalian host is the most evident medium of communication of many diseases. In other instances, contamination of food sources by animals or their excreta is the mechanism; or again, the food derived from mammals may itself become the offending member. The laity has become increasingly conscious of these basic principles in the threat of biological warfare. In this respect, infectious agents transmissible from domestic or other animals might be used against an enemy. Or, purely epizootic inocula might be used to dislocate a foreign market and economy.

The World Health Organization established an Expert Group on Zoonoses in 1950. Their report (1953) lists 86 diseases transmissible between man and other vertebrates. This discussion will be restricted to those diseases encountered in this geographical area. Especial emphasis will be given to the diseases of more frequent incidence and greater risk to the community.

Anthrax, Glanders, Rabies

Of traditional interest are anthrax, glanders, and rabies. In recent years little knowledge has been added to the basic understanding of anthrax and glanders. Penicillin and Aureomycin have an assured place in treating anthrax, whereas sulfadiazine and streptomycin are preferred in glanders. The greatest growth in relation to rabies has been the promise of more prompt and more certain prophylaxis. Yet the strict quarantine, so effective in Great Britain and elsewhere, has never been exploited to a reasonable degree in the United States. The reservoir among wild animals will remain a threat of varying proportions and gravity. On occasions an unexpected hazard looms. For some time, records of rabies in vampire bats have been made in Trinidad, South and Central America. In Florida and Pennsylvania, rabies has recently been discovered in the insectivorous hoary bat (1954). Since this species is found throughout the country, it must be added to the possible threats in human spread.

Tuberculosis

The control of bovine tuberculosis in the United States is one of the brightest chapters in preventive medicine. Only a hint of its grievous threat to human health and life may be gained by a glance at our past and another at the less favored peoples of other countries. Scarcely a generation ago, tuberculosis of the cervical lymph nodes (scrofula), mesenteric lymph nodes (tabes mesenterica), and bones and joints was commonplace. The bovine tubercle bacillus was the overwhelmingly dominant offender. With improved milk production, tuberculin testing of herds, and pasteurization of milk, these forms of tuberculosis have steadily diminished, practically to the vanishing point. Certain foreign countries lagged far behind in this area of public health and preventive medicine so the scars of tuberculous cervical lymphadenitis and the deformities of tuberculous arthritis and osteomyelitis are still common.

Brucellosis

Brucellosis remains an important disease, both to domestic stock and man. Bang's disease is an economic threat to the dairy industry in several directions. From the present viewpoint, brucellosis is an important industrial disease. A majority of its sufferers contract the disease through immediate contact with the fetal membranes or placenta of the aborting cow. Butchers of beef and hogs have a similar hazard of infection. In the

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experience of the University Hospitals, Madison, Wisconsin, the ingestion of milk from affected cows or goats more regularly accounts for brucellosis within the farm family since the false economy of consuming contaminated milk at home still prevails in certain quarters. Singularly, the disease is uncommon in infancy when milk is the universal food. While the several varieties of Brucella, *i.e., Brucella melitensis* (goats), *Br. suis* (hogs) and *Br. abortus* (cattle), have a definite predilection for a given species, cross infections among the several types are frequent. However, the transmission between humans is practically unknown.

In man, after an incubation period of one to three weeks, the disease has its inception by chills, fever, and sweats. In a minority, the onset may be marked by malaise, weakness, rigor, and aching. The aching may be general, or there may be muscle aching and backache. Arthralgia may give way to frank arthritis with or without effusion. Characteristically, the patient experiences a growing lassitude and aching in the afternoon. The headaches may be very severe. Frank chills are succeeded by rises of temperature to 101 to 104 F. After several hours, these febrile bouts subside with drenching sweats. The following day, the patient may resume his duties with little residua of his experience of the preceding night. With the continuance of the process, weakness and wasting advance; but, among the serious infectious diseases, only chronic meningococcemia may continue as long with as little disability. Incidentally, the undulant febrile course is unusual in this country. During the acute episode, flushing of the skin and an evanescent macular eruption over the lower thorax and upper abdomen may be observed. Lymphadenopathy may be general but not extreme in degree. Moderate splenomegaly is the rule, and the liver is usually enlarged. Serious complications attend the involvement of the heart, lungs, and liver. Chronic brucellosis is a real entity, and its manifestations are legion; but the scrap-basket diagnosis of chronic brucellosis, on the basis of low titers of agglutinins against Brucella in the blood of patients with obscure clinical pictures, should be discouraged.

The definitive diagnosis of brucellosis in man depends upon the isolation of Brucella in blood cultures. If there is failure of this demonstration, ascending titers of agglutinins exceeding 1:100 are next in value. Of little practical use are the complement fixation and the opsonocytophagic index. Experience has eliminated the brucellergin skin test as a confusing detail in subsequent observations of the agglutinin titer. Furthermore, its sensitization may persist for a long time after the subsidence of the actual infection.

The management of brucellosis begins (and should end) in its source in domestic animals. Until this reservoir is eliminated, all efforts to meet the disease in man will prove abortive. Pasteurization of milk is a further barrier to the spread. Vaccination of butchers, veterinarians, and other workers who may have repeated exposures has been advocated without great success. For the management of the actual disease in the human, Aureomycin has largely displaced the earlier favored streptomycin-sulfadiazine therapy.

Tularemia

Tularemia has become a zoonosis of significance in certain quarters. *Pasteurella tularensis* is the cause of widespread and highly fatal epizootics among wild animals. Man is usually infected through handling affected wild rabbits; but the disease may be transmitted by the bite of the deer fly and other arthropods, inhalation of infected material, and ingestion of incompletely cooked meat. After an incubation period of one to ten days, the patient experiences severe headaches, vomiting, chills, and fever. The temperature ranges from 101 to 105 F. Prostration is usually extreme. General aching and muscular weakness add to the gravity of the picture. Delirium and coma are common. After a stormy course of two to four weeks, the temperature subsides by lysis.

The clinical manifestations fall naturally under several acceptable headings. In the crytogenic or typhoid type, the constitutional symptoms dominate the picture with extreme toxemia and coma. The cutaneous form is foreshadowed by inflammation of an earlier abrasion. This portal passes from a papular to a pustular to a necrotic stage. A sluggish, punched-out ulcer succeeds. A reactive regional lymphadenitis with connecting lymphangitis supervenes. These lymph nodes frequently suppurate and, in turn, leave indolent secondary ulcers or sinus tracts. Invasion of the conjunctiva is signalized by lacrimation, pain, and photophobia. Small, dis-

crete, yellow nodules appear in the inflamed conjunctiva. Chemosis is extreme. A greyish exudate covers the conjunctiva; and ulceration, minimal or extensive, occurs. While complete resolution is the rule, serious sequelae, even complete blindness, may result. Among laboratory workers, pulmonary invasion is not infrequent. Inhalation is the assumed route. Occasionally, pulmonary involvement may be metastatic from a primary tularemic process elsewhere. In the simpler invasions of the lung, the course and the paucity of physical signs may suggest primary atypical pneumonia. In the more serious involvement, abscess, gangrene, and cavitation are the sequence. The pleural involvement may lead to empyema. Upon the ingestion of affected game, severe inflammation of the mouth and pharynx with necrosis and ulceration may occur. Cervical and submaxillary lymphadenopathy usually succeed. Nausea, vomiting, abdominal pain, and diarrhea attend abdominal involvement. Purulent peritonitis, pleuropulmonary and cardiac involvement are the most serious complications. The isolation of the *P. tularensis* and agglutination, complement fixation, and intracutaneous sensitization tests conclude the diagnosis.

The ultimate elimination of tularemia rests in a program of education. Until an effective vaccine or antiserum is available, all individuals handling or dressing wild rabbits should protect their hands with gloves. Laboratory workers with *P. tularensis* should be masked. Although man-to-man infection with this organism is highly improbable, gloves should be worn by medical attendants in dressing the local suppurating lesions. Streptomycin is virtually a specific in the treatment of the active disease in man.

Salmonellosis

Among the bacteria infecting domestic animals, with a threat of human transmission, Shigellae and Salmonellae deserve further attention. The former has only a small place in the possible communication of *Shigella dysenteriae* from dog to man. Crawling babies and children are especially vulnerable through their intimate contacts with dogs. Salmonellosis involves an entirely different problem. Fresh duck eggs, dried chicken egg powder, poultry meat, and ground meat of a variety of origins may be contaminated and convey the infection to the susceptible human host. Chills and fever may initiate the attack. Nausea and vomiting are not unusual. Anorexia, abdominal distress, cramps, and diarrhea of varying severity complete the typical clinical picture. Arthralgia may be a prominent feature.

Obviously, infections with Salmonellae may be prevented by adequate precautions at the source and by proper heating in the preparation of food. Mass vaccination is the rule in military and potentially exposed civilian personnel. Chloramphenicol is the antimicrobial agent of choice.

Endemic Typhus

The Rickettsiae play an important role in this relation. However, for the present consideration by reason of geographic limitations, only endemic typhus fever, Rocky Mountain spotted fever, and Q fever require our attention. The endemic form of typhus fever is caused by *Rickettsia mooseri*. The rat flea is the usual vector; and the reservoir is a rodent, commonly the rat. A natural cycle is the rat to the flea to the rat to the flea. Man is on a dead-end street, and communicability from man to man is highly improbable. Although endemic or murine typhus fever is naturally limited to southeastern and southwestern states, modern transportation has obliterated narrow geographic limitations.

After an incubation period of six to fourteen days, the patient experiences constitutional symptoms of chilling, malaise, aching, headache, backache, and weakness. The reaction is distinctly less marked in murine typhus than in epidemic typhus fever. The eruption is less extensive and persists for a very short period of time. However, its distribution follows the pattern of the epidemic form in the escape of the face, with an involvement of the trunk and extremities, excepting the hands and feet in all save the desperately ill. The initial macular eruption becomes petechial, but there is rarely a progression to local gangrene. Fever of 102 to 103 F. persists from nine to twelve days and subsides by lysis. Rarely are complications encountered.

The leukocyte count is usually slightly elevated. Specific agglutination tests and complement fixation antibodies are established by the end of the first week. The ascending titer usually confirms the diagnosis. The agglutination test for *Proteus*

OX–19 is positive by the beginning of the second week. The isolation of Rickettsiae from the blood stream by appropriate methods is applied only in special laboratories. Interestingly, biopsy of the skin of suspected individuals has been used as a diagnostic detail in certain quarters. Depletion of the serum protein is less common than in epidemic typhus fever, but it should be observed as a prognostic element along with the nonprotein nitrogen. A decline in serum protein and a rise in nonprotein nitrogen have a grave significance.

The life cycle of the *Rickettsia mooseri* affords two vulnerable points of attack upon the disease. Obviously, the eradication of rats and of fleas would remove both the reservoir and the vector. Since both objectives are capable of accomplishment, a concerted attack in this area would be most effective. Aureomycin and Terramycin have proved their effectiveness in combating murine (endemic) typhus fever. This circumstance has led to the consideration of the use of such antimicrobial agents in prophylaxis. Chloramphenicol, while effective in the treatment of endemic typhus fever, presents the limited risk of leukopenia and, for this reason, must take a secondary place until further information is available.

Rocky Mountain Spotted Fever

The geographic connotation of the term, Rocky Mountain spotted fever, has not been sustained by epidemiologic studies, since isolated instances of the disease have occurred widely in the United States as well as other countries. The etiologic agent is the *Rickettsia rickettsii;* and the reservoirs are rodents, particularly rabbits. The vector in the far West is the wood tick, *Dermacentor andersoni,* in the East, the dog tick, *Dermacentor variabilis.* The circumstance of the habitat of the two different vectors explains the higher incidence of Rocky Mountain spotted fever among adult males, particularly herdsmen, in the West, and among women and children in the East. In its natural history, the Rickettsia may be transmitted from the tick to its larvae without passing through an intermediate stage. However, the ticks cannot transmit the disease without the nutriment of the alien blood of vertebrates.

After an incubation period of five to eight days, Rocky Mountain spotted fever has a very stormy onset. The temperature rises within 24 to 48 hours to 103 to 105 F. Extreme prostration, headache, nosebleed, backache, and generalized malaise prevail. Weakness is conspicuous; and the mental symptoms may include restlessness, insomnia, delirium, coma, and convulsions. At times there is evidence of meningeal irritation in muscular rigidity and opisthotonos. Occasionally deafness, visual disturbances, and mental confusion may persist for several weeks into convalescence. On the second or third day of the disease, the eruption appears as macules about the wrist and ankles and spreads to involve the entire body. Unlike typhus fever, there is invasion of the hands, feet, and face. The hemorrhagic phase promptly succeeds the erythematous and macular eruption. Desquamation is the rule on subsidence. For a considerable period of time after convalescence, vasodilatation may bring out the subcuticular mottling and residual pigmentation at the site of the previous eruption. Photophobia and myosis are not uncommon. The temperature range, from 103 to 105 F., exhibits wider swings than in typhoid or epidemic typhus fever and runs a course of two to three weeks, to subside by slow lysis over a period of three to seven days. During the febrile course, the pulse is disproportionately rapid and the respiratory rate increased. Myocardial injury may lead to a fatal outcome. Renal complications may terminate the picture. Thrombosis and gangrene of the lobes of the ears, tip of nose, fingertips, soft palate, scrotum, prepuce, buttocks, and vulva are much more common in Rocky Mountain spotted fever than in other rickettsial diseases.

The leukocytes number 12,000 to 15,000 with a mononuclear increase. The Weil-Felix reaction becomes positive (OX–19 and OX–2) in the second week. Agglutinins, complement fixation reactions, and neutralization of the virus complete the serologic studies. The serum protein will be lowered as a rule and affords a prognostic index. Azotemia is an ominous sign. The urine may show albumin, red blood cells, and an occasional cast. Conduction faults are disclosed by electrocardiography.

The study of the mortality of Rocky Mountain spotted fever affords an interesting detail in its ecology and epidemiology. Before

vaccination and antimicrobial therapy became available, the mortality in the Bitter Root Valley of Montana was 80%, whereas the figure for a similar group in the Snake River Valley was 5%. Eradication of rodents and the control of ticks by avoidance of contact, careful handling to remove attached ticks without crushing, and eventual elimination of this vector are the logical points in prevention. Vaccination was earlier invoked with some success, but the chemoprophylaxis of Rocky Mountain spotted fever has received increasing attention in recent years. Aureomycin and Terramycin are the preferred antimicrobial agents for the active treatment of Rocky Mountain spotted fever. Chloramphenicol is likewise effective but, for the present, holds a subsidiary place.

Q Fever

One of the most fascinating of the zoonoses is Q fever. This rickettsial disease, caused by the *Coxiella burnetti,* was first described in Queensland, Australia; but its designation refers to its problematic nature rather than its origin. Its geographic limits have not been fixed. However, its epidemic appearance in as removed areas as the Mediterranean basin and North America gives some clue to its range if not its ubiquity. Limited epidemics have occurred in Amarillo, Texas; Chicago, Illinois; and Oakland, California, among other communities in this country. The isolation of the *C. burnetti* from a considerable percentage of milk samples in the Los Angeles milkshed is a matter of further concern. The epizootic cycle is from the tick to the bandicoot to the tick in Australia. Cattle and men are incidentally involved. The animal reservoir in this country is uncertain. However, with few exceptions, Q fever has appeared among people closely associated with cattle and sheep. The exceptions have occurred in people exposed in the laboratory or to dust from contaminated areas. It is postulated that the dried feces of affected ticks are the medium of infection in these instances.

The period of incubation ranges from 19 to 25 days, and it is signalized by fever, malaise, headache, and cough. Hemoptysis may occasionally occur. Usually the cough is harassing and nonproductive. A faint macular eruption has been reported. Splenic enlargement is not infrequent. The pulmonary signs are minimal. Usually fine moist rales occur in patches, and rarely the signs of migratory consolidation prevail. Pleural involvement is unusual. The temperature is elevated for several days. The x-rays of the thorax are most disquieting in the disclosure of the widespread distribution of bronchopneumonia. Beyond this detail, the leukopenia or slight leukocytosis, negative Weil–Felix reaction, and the presence of specific complement fixation and agglutination tests conclude the diagnosis. On occasions, the relatively benign course of Q fever may be complicated by pleurisy, arthritis, orchitis, or epididymo-orchitis.

The control of Q fever poses one of the significant problems in public health. Neither the reservoir nor the vector has been unequivocally fixed in the United States. Until its mode of transmission in this country is established, the usual plan of attack for the rickettsial disease would be fruitless. Vaccination and chemotherapeutic prophylaxis for potentially exposed personnel have been suggested but not widely applied. Aureomycin is the preferred antimicrobial agent for the treatment of active Q fever in man. Chloramphenicol has the disadvantage of possible depression of leukopoiesis, but it is effective.

Psittacosis

Among the viral diseases, after rabies, psittacosis (ornithosis) particularly attracts notice in the present relation. The broader term, ornithosis, undoubtedly should replace psittacosis since birds other than the Psittaciformes have been incriminated in its spread to man. Indeed, when the British authorities questioned the propriety of bringing American pigeons into England for the Signal Corps of the United States Army in World War II, the danger of the introduction of ornithosis was cited as an objection. The day was saved when four of six native pigeons studied proved to have the disease. Undoubtedly, the greater intimacy of human contact with the parrots, love birds, and parakeets explains their major responsibility. Several strains of the responsible filterable virus have been isolated. This agent is found in the nasal secretions and the dejecta of sick birds. Man is infected by inhalation.

An incubation period of one to two weeks is encountered. In general, infections derived

from parrots are more prostrating than those from pigeons. The constitutional symptoms, malaise, headache, backache, and fever, are nonspecific. A nonproductive cough ensues. The remittent fever continues for ten days to three weeks and then subsides by lysis. Severe headache, restlessness, and delirium have a grave prognostic significance. The accustomed patchy pneumonia gives few symptoms, as cough and blood-streaked sputum. The signs of consolidation are likewise scanty, and the x-ray determination of extensive patchy densities may be quite unexpected. The diagnosis will be suspected by the recognized exposure and the pulmonary changes revealed by x-ray. The isolation of the virus from the sputum and complement fixation studies complete the ultimate support in the well-equipped laboratory.

The eradication of psittacosis in man depends upon the avoidance of contact with pigeons, parrots, and related birds. Infectious precautions must be enjoined in the care of patients with this disease. Terramycin and Aureomycin are favored antimicrobial agents in the treatment of psittacosis.

Other Viral Diseases

Of considerable interest among veterinarians and clinicians are two other viral diseases. While Newcastle disease is essentially an epizootic infection of fowl with a serious economic hazard, it may occur in laboratory or poultry workers exposed to the virus. After an incubation period of several hours to two days, the susceptible host experiences photophobia, lacrimation, and burning sensations in the eyes. Headache, general malaise, and chills are common constitutional symptoms. Little or no febrile response appears. Enlargement and tenderness of the preauricular lymph node may be anticipated. Newcastle disease runs its course in one to two weeks in man. The diagnosis is suspected by the history of exposure to sick fowl. The definite conclusion may be derived by specific serologic tests and the isolation of the virus. Prophylaxis in man depends upon his protection against infected fowl. No specific agent for active treatment has been discovered.

The collaboration of workers in the College of Agriculture and the Medical School at the University of Wisconsin has established the transmission of the virus of vesicular stomatitis to man under certain conditions. While this disorder may not prove a serious threat to health, it at least adds one more industrial hazard to laboratory and domestic livestock workers. Certain other related viral diseases belonging to the group of zoonoses are omitted from the present consideration.

Cat-scratch fever is a viral disease the origin of which can usually be traced to the scratch or the bite of a cat a few days before the inception of symptoms. Its incidence or recognition is increasing steadily. The portal of entry usually becomes inflamed and is eventually represented by a pustule or furuncle. Chills, fever, and malaise initiate the constitutional reaction, which may persist for a week or more. Regional lymphadenopathy is the rule, and these nodes may suppurate. A macular rash over the arms and legs has been described. Antigens produced from the affected lymph nodes promise a specificity in intradermal testing. The prevention of cat-scratch fever obviously implies avoidance of contact. Certain reports indicate favorable therapeutic response to Aureomycin and Terramycin.

Leptospirosis

Leptospirosis looms large in the present connection. Among the Leptospirae with especial threat in this country are *Leptospira icterohaemorrhagiae* and *Leptospira canicola*. *L. icterohaemorrhagiae* infects dogs and rats, and *L. canicola*, dogs. *Leptospira pomona* finds cattle and swine its usual hosts, but evidence of human invasion is accumulating. However, its consideration is presently omitted. Other Leptospirae will undoubtedly enter the list of zoonoses as the knowledge extends.

L. icterohaemorrhagiae is communicated to man from the rat or dog by contact or contamination of food and drink with the infective urine. Since the infected rat and dog may excrete urine containing the Leptospirae for months or years, the chance of contamination multiplies. The method of its spread particularly threatens workers in mines, sewers, and fisheries. The survival of the Leptospirae in slightly alkaline media makes bathing in water contaminated by murine dejecta dangerous. Its clinical expression in man is termed Weil's disease, lepto-

spirosis, spirochetal or infectious jaundice. The usual incubation period is 10 to 20 days. The onset is fulminating with chilliness, general aching, headache, and prostration. Anorexia, nausea, and vomiting may be misleading in the attendant abdominal pain and muscular spasm. The fever ranges from 101 to 105 F. Conjunctival suffusion and petechiae are common. Jaundice occurs only in from 30 to 40% of patients. Significantly, the renal involvement overshadows the hepatic injury in many instances. Recent studies emphasize the relationship between leptospirosis and benign aseptic meningitis. Headache, chills, high fever, conjunctival injection, erythematous eruption, herpes, stiff neck, and prostration may be encountered in these patients.

The diagnosis of Weil's disease may be made *by experts* upon the dark-field demonstration of *L. icterohaemorrhagiae* in the blood or urine. This highly technical procedure must never be entrusted to the routine laboratory, since so many artefacts may confuse the issue. Animal inoculations will be of assistance in this pass. Agglutination titers are much more reliable and ascend to extremely high levels in the acute illness. Other serologic studies are available in special laboratories. The most effective measures in the prophylaxis of Weil's disease involve the eradication of rats and the protection of the food and water supply from rat or dog contamination. Early administered, penicillin affords good therapeutic results in Weil's disease. Some reports indicate certain advantages of Aureomycin.

Canicola fever has been reported in isolated instances or small epidemics in recent years in the United States. The natural habitat of *L. canicola* in the dog presupposes intimate contact of human subjects or the contamination of the food or water supply with infected canine urine. High fever, general muscular aching, conjunctival injection, jaundice, and hepatomegaly appear. Certain instances of benign aseptic meningitis have this etiology. Agglutination and other serologic studies will conclude the leptospiral responsibility and differentiate its forms. Prophylaxis against *L. canicola* presupposes a protection from the carrier dog. In the active treatment of canicola fever, Aureomycin and Terramycin have professional favor.

Trichinosis

Trichinosis still constitutes an important zoonosis. Necropsy studies indicate that 16% of the adult population in the United States is affected. The larvae of the *Trichinella spiralis* encysted in the muscles of pork are liberated by the activity of the digestive juices. The free larvae mature, copulate, and reproduce in the duodenum and jejunum. The fertilized female hatches the ova in utero after burrowing into the depths of the mucosa. From this position, on extrusion the larvae enter the lymphatics and lacteals of the upper small intestines. Thence they are carried to all parts of the body—with a special predilection for the voluntary muscles. The clinical manifestations of trichinosis in man bear a definite relation to the phases of invasion, migration, and encystment. Of course, the burden of the infestation has some bearing upon the intensity of the symptomatology. Several days after eating the infected meat, the victim will experience nausea, vomiting, cramps, and diarrhea. From the seventh day, migration causes muscular pain, tenderness, and weakness. Edema may appear over the affected groups of muscles, but more characteristic are the chemosis and subconjunctival hemorrhages. Urticaria and other cutaneous eruptions are interpreted as allergic manifestations. Special symptoms, as dyspnea, may arise from a peculiarly heavy infestation. The fever may rise to 103 to 104 F., and evidences of meningeal irritation supervene.

Aside from the history of several persons experiencing like symptoms after partaking of the same food, trichinosis will be diagnosed by the clinical course with certain laboratory supports. Eosinophilia of high degree (20 to 70%) is the rule. Precipitin, complement fixation, and flocculation tests are part of the diagnostic battery; and the cutaneous test, utilizing dried powdered trichinae as the antigen, is gaining clinical favor. The demonstration of the encysted larvae in striated muscle upon biopsy is the clinching diagnostic nail.

The eradication of trichinosis involves the coordination of a number of relatively simple details. The elimination of garbage as a food for hogs would appreciably reduce the hazard. Though a minor factor, the rat does contribute and can be eradicated. The proper cooking of or the avoidance of uncooked pork would promptly write off this

expensive zoonosis. Recent experiments have demonstrated an unusual application of atomic waste to destroy larvae in meat. Anthelmintic therapy is futile except on suspicion. When symptoms have occurred, it is too late to initiate the elimination of the larvae. Indeed, no specific treatment has been devised; but there are a number of clinical reports indicating a remarkable place for cortisone in the treatment of trichinosis. From the spectacular amelioration of the more troublesome symptoms under cortisone, they may be interpreted as allergic or antigen-antibody reactions.

The dangers of taeniasis are familiar. The definitive host in *Taenia solium* (pork), *Taenia saginata* (beef) and *Diphyllobothrium latum* (fish) is man; but his infestation depends upon the ingestion of flesh containing the cysticercus or larval form of the respective tapeworm. The occasional cysticercus phase in man may lead to grave local pressure as in the brain or other organs. *T. solium* is overwhelmingly the most common tapeworm involved in this relation, and its larval form is termed *Cysticercus cellulosae*. The occurrence of taeniasis could be prevented by the adequate cooking of all meat. Except for the addition of Atabrine, the therapy of tapeworm infestation in man has undergone no radical change in recent years.

The *Echinococcus granulosus* finds the dog as the definitive host and man as the intermediate. Man shares this unenviable position with sheep, hogs, and cattle. The hydatid cyst, which develops in the intermediate host, may escape notice for years in the human. Then symptoms may develop from pressure in the abdomen, chest, cranial cavity, or heart. Rupture of a hydatid cyst intraperitoneally is dangerous from shock, peritonitis, or secondary masses arising from daughter cysts. The reaction to intracutaneous antigens may prove helpful in the diagnosis. Complement fixation and other serologic tests may be invoked. General hygienic measures, involving the dog especially, should reduce, if not abolish, this hazard. The treatment of echinococcosis is still symptomatic and surgical.

The dependence of man on animals is as ancient as history. A truly comprehensive consideration would include the fungus infections and certain cutaneous disorders of animals occasionally transmitted to man. No such objective was set. Indeed, the design of this presentation is to bring into focus a very interesting and important group of diseases, termed zoonoses, transmissible between certain lower animals and man. The life cycle of certain of the infectious etiologic agents and the natural history of their manifestations afford obvious points for attack. With new weapons, laboratory and clinical approaches, scientific advances grow apace. In the control of these diseases, every scientific facility must be enlisted. An unexcelled opportunity for the coordination of medical and veterinary skills in this common interest is afforded. Only by such a consolidated approach can the zoonoses be eradicated.

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Carcinoma of the Thyroid*

By R. L. MacCORNACK, JR., M. D.,** Whitehall F. GLASSY, M. D.,*** Marshfield and R. H. SEGNITZ, M. D.**** Milwaukee

Introduction

THIS writing is to correlate the morphology, biological characteristics, and treatment of patients with carcinoma of the thyroid, and to compare the findings at Milwaukee County General Hospital with those at other institutions. The records and pathologic material of 21 patients with cancer of the thyroid gland with an established diagnosis admitted to Milwaukee County General Hospital from 1940 through the first six months of 1955 were carefully studied. Follow-up data were obtained in all cases.

To correlate histology and behavior it is vital to use a descriptive, accurate, and widely accepted classification. For that reason we have employed the classification proposed by Warren and Meisner.[1]

In classifying the tumors histologically, we placed each in the type of its most malignant component. If the primary tumor had well-differentiated areas in it and metastases were undifferentiated, it was classified as undifferentiated.

Pathology and Incidence

The differentiated cancers of the thyroid have two subdivisions—the papillary and the follicular. The papillary type usually comprises about 55% of all thyroid malignancies. This figure was arrived at by averaging the incidences of the series at the Mayo Clinic,[2] Massachusetts General Hospital,[3] and Cancer Memorial Hospital, New York.[4] In our series the incidence was 23%.

Grossly, the papillary cancers tend to be small, usually not more than two or three centimeters in diameter. This is especially true in children. The erroneous "lateral aberrant thyroid" syndrome was thought to be common in the young, but proved to be only a lateral cervical lymph node metastasis from an occult carcinoma of the thyroid.[3] In our series there were 5 pure papillary tumors, and of the 5 only 3 were smaller than three centimeters in diameter. Microscopically, these tumors exhibit papillary infoldings but still maintain some of the normal architecture of the gland.

TABLE 1—*Classification and Comparative Incidence of Thyroid Carcinomas*

	No. of Cases	Our Incidence	Combined Incidence at Other Hospitals
Differentiated			
Follicular	2	10%	20%
Papillary	5	23%	55%
Undifferentiated			
Small cell	8	38% | 67%	23%
Giant cell	6	29% |	
Miscellaneous	0	0	2%

Although the usual incidence of the follicular type is given as 20% of all thyroid malignancies, our incidence was 10%. This type is not usually so well circumscribed as the papillary tumors and tends to be larger than the papillary type. Two patients in our series had pure follicular carcinomas, both more than three centimeters in their greatest diameter. One of the two patients had had pelvic surgery at this hospital five years prior to her admission for thyroid disease, and at that time a smaller nodular goiter that may well have been malignant was described on physical examination. Because of the follicles seen microscopically, these tumors have previously been called alveolar carcinoma and adenocarcinoma; however, the term follicular carcinoma is preferable because it implies follicles as they exist in a normal gland, and one always finds malignant follicles that resemble normal follicles.[5]

The undifferentiated cancers are divided into small cell and giant cell tumors on the basis of morphology alone, for there is no difference in behavior between these two

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types. These tumors are usually large and rapidly growing, and they show great cytologic variability; the cells may be round, spindle-shaped, small or large.

In the **miscellaneous group** are included squamous cell carcinomas, the sarcomas, the Hürthle cell tumors, and other rare types. The usual incidence of these is 2% ; we had none.

Because this is a small series of older patients, the usual age incidence is not indicated. Well-differentiated carcinomas are more common in the young,[2,5,6] undifferentiated ones in the older age groups.

Behavior

Papillary carcinoma is relatively slow growing. In patients under 40 years of age a thyroid malignancy is likely to be papillary and slow growing.[6] According to a recent report on thyroid carcinomas in the San Francisco Bay area,[7] there were 6 cases in patients in the second decade and 20 in patients in the third. The 6 thyroid carcinomas in patients in the second decade, and 11 of the 20 in patients in the third, had metastasized at the time of the report. From this it was concluded that the papillary carcinoma was more malignant before the age of 30, but there were no statistics on survival or how these cases responded to treatment. Other reports dealing with thyroid carcinoma in youth show that, despite the frequent metastases at the time of the first examination, the tumor is relatively benign and slowly progressive.[5,8] Consequently, the survival rate is usually good. Often patients in the second decade have the initial manifestations of the disease in childhood. In many series reported in the literature death from papillary carcinoma is infrequent. In our cases only 1 patient failed to live five years.

Papillary lesions tend to metastasize to regional lymphatics. Nodal involvement may be massive or limited. Fortunately, the metastatic deposits in the node do not tend to invade the capsule or the surrounding tissue and as a result are usually resectable. In only 1 of our 5 cases of purely papillary carcinoma was there evidence of distant metastases by x-ray only. One important fact often overlooked, and emphasized in our series, is the presence of anaplastic metastases from a purely papillary adenocarcinoma. It is also to be emphasized that the pathologist must make multiple sections of a thyroid carcinoma in order to rule out a variable histologic picture. Consequently, the prognosis of papillary carcinoma must then be guarded to a degree.

Follicular carcinoma is often characterized by early blood vessel invasion, which causes local thrombosis of the vessels. It does not spread via the lymphatics until it breaks through the capsule of the gland, since adenomas have no lymphatics. It is this type that sometimes is difficult to differentiate histologically from benign adenoma. Some pathologists rely on cellular difference, and others must demonstrate blood vessel invasion. After the capsule is invaded, there may be involvement of lymphatics. With this type of tumor, blood-borne metastasis is far more common than lymphatic spread. Being a well-differentiated tumor, it is rather slow growing in spite of early distant metastases. One of our patients lived four years with widespread metastases, and the other had

TABLE 2—*Histology and Behavior of Thyroid Carcinoma*

	No. of Cases	Sex		Average Age	Pre-existing Goiter for More Than 5 Yrs.	Local Metastasis	Distant Metastasis	5-year Survival
		M	F					
Differentiated								
Papillary	5		5	48	3 (60%)	4 (80%)	1 (20%)	67%*
Follicular	2		2	47	2 (100%)	2 (100%)	2 (100%)	50%
Undifferentiated								
Small cell	8	2	6	67	4 (29%)	14 (100%)	10** (71%)	0
Large cell	6	2	4					
Miscellaneous	0							

*Two recently treated in 1955.
**Autopsy proof in 6 cases.

thyroid cancer for at least four years before initial therapy (table 2).

The group of tumors classified as **undifferentiated** are typically rapid growing. Early local invasion, as well as widespread blood stream invasion, is common. Autopsies were performed in 8 of our cases in which there was anaplastic carcinoma—2 patients had extensive local metastases only, and 6 had both local and distant widespread metastases. There were no five-year survivals in this group. Survival is usually a matter of months once the diagnosis has been made. We had 1 patient, treated in 1954, who survived one year.

Well-differentiated carcinomas often exist for years before the patient seeks medical advice or before the physician advises investigation and treatment. It is a well-established fact that a low-grade malignancy may be present as a lump in the neck, resembling a benign adenomatous goiter, and then suddenly grow and metastasize quickly as an anaplastic carcinoma in the middle-age period. Two of our cases exemplify a differentiated primary tumor terminated by anaplastic metastases (table 3).

1. A 70-year-old female had a swelling in the neck of five years' duration which grew more rapidly the two years prior to surgery. The surgical specimen showed a well-differentiated papillary carcinoma. One year later the patient suddenly expired of a pulmonary embolus from a deep thrombophlebitis. At autopsy she had multiple and distant metastasis of the highly anaplastic type.

2. A 72-year-old female who had had a goiter for 20 years died of carcinoma of the thyroid. At autopsy widespread metastases of highly anaplastic type were found. The primary thyroid tumor showed both well-differentiated papillary and well-differentiated follicular carcinoma.

Four of our patients had long-standing goiter which eventually showed carcinoma (table 3).

1. A 51-year-old female presented with a history of a goiter since age 18. The goiter had been slowly enlarging for 10 years. Biopsy revealed a papillary adenocarcinoma. There was also x-ray evidence of metastasis to the lungs. The patient was treated by x-ray. After receiving the treatments, she moved to Michigan. A follow-up by letter to her private physician revealed that she died one year later of carcinoma of the thyroid.

TABLE 3—*Summary of 6 Representative Cases Showing That a Well-differentiated Primary Tumor May Terminate in Anaplastic Metastasis and That Long-standing Goiter Does Not Preclude Carcinoma*

Age	Years of Existence of Neck Tumor	Type of Primary Tumor	Type of Metastasis
70	5	Papillary adenocarcinoma	Anaplastic
72	20	Mixed papillary and follicular	Anaplastic
51	33	Papillary adenocarcinoma	Not determined as death occurred out of city
39	16	Follicular	Follicular
55	37	Follicular	Follicular
71	50	Papillary adenocarcinoma	Papillary

2. A 39-year-old female presented with a swelling of the neck, which had been present for 16 years. Partial thyroidectomy revealed a well-differentiated follicular carcinoma. Four years later she entered the hospital because of a pathological fracture of the right femur. She died two years later of carcinomatosis. At autopsy the multiple and distant metastases were of the well-differentiated follicular type.

3. Another follicular carcinoma was detected in a 55-year-old woman who had had a goiter since age 18. She entered the hospital because of a right upper quadrant mass and died of liver metastases of the follicular type.

4. A female, 71 years old, had a swelling in the neck for 50 years. In 1948 the thyroid was removed at another hospital for cosmetic reasons. The pathologic report was papillary adenocarcinoma. A recurrence with lateral metastases developed, and the patient had a right radical neck dissection here in 1955.

Treatment

The results of treatment in our series can be briefly given. Three of the 21 patients are still living. The first of these is an 18-year-old female who had a papillary carcinoma treated by total lobectomy on one side and a subtotal lobectomy on the other. She is free of disease seven years after surgery. The other two are women, ages 66 and 72, with papillary carcinoma with local metastases. They had radical surgery in 1955.

It is interesting that 8 of the 21 had no treatment at all. Most of these were terminal or preterminal or died suddenly—1 of a coronary occlusion and 2 of aspiration sec-

ondary to hemorrhage from tracheal infiltration, causing tracheo-esophageal fistula.

If one is to treat carcinoma of the thyroid, he must be concerned with marked variations of opinion as to its biological behavior, frequency of occurrence with respect to cell types and age, and the actual histopathology of the disease.

One aspect of the disease about which there are differences of opinion is the relative danger of single nodules. At one time it was quite generally accepted that solitary nodules of the thyroid were more apt to be malignant than multiple nodular goiters. More recently, several series of cases have been reported in which there was a greater incidence of malignancy in multiple-nodular glands.[4]

It has been suggested that all nodular goiters have surgery; but such goiters are very common, and probably less than 1% are malignant.[9]* High percentages of nodular goiters with malignancy reported by some clinics may be explained by referral of patients from smaller institutions. Many nodular goiters are discovered only to be forgotten, and many are completely overlooked.

The question is: What lesions should cause suspicion? The answer is not obvious in every case, but any changing nodule in the thyroid gland should be explored. Probably every nodule in the gland of a child or young adult should be resected. It must be emphasized that every swelling in the thyroid gland should be carefully evaluated and closely followed if left *in situ.*

Another aspect of this disease about which opinions so often vary is the relative malignancy of thyroid cancer in children. Winship and Chase[10] feel there is no difference between the degree of malignancy of thyroid carcinoma in children and that in adults, whereas Alexander[7] believes that thyroid carcinoma in children is the more malignant disease.

The most serious differences of opinion about these thyroid tumors concern basic classification. In some series malignant adenomas are classified separately from adenocarcinoma.[7] In some instances mixed papillary and follicular carcinomas are classified as papillary. A more uniformly accepted histologic classification would allow for a better understanding of the biologic behavior and therapy of these tumors. It seems that this would allow collections of many small series to be grouped together in such a way as to give more valid conclusions. Many series of cases of thyroid carcinomas are small because the lesion is not common. Large series of collected cases are apt to contain some selected material.

The complicating features of the disease itself make it more difficult to deal with. As noted above, a single carcinoma may not show only one pattern. A pattern of an undifferentiated tumor may well be overlooked in a well-differentiated papillary or follicular carcinoma. Only one small area of a slowly growing differentiated tumor may show a poorly organized anaplastic process. Also, as has been mentioned, a well-differentiated tumor may metastasize as an anaplastic one; and as with other cancers, there is often some variability in the behavior of a certain cell type from one patient to another.

It would be ideal if a general plan for treating this disease could now be presented. It is questionable, however, if such could exist in a disease about which there is so much disagreement.

Carcinoma of the thyroid gland is a complex disease from the standpoint of morphology and biologic behavior; so, too, it is not a simple one from the standpoint of treatment. Because of these vagaries, much can be said for and against any positive plan for dealing with this disease. There is no doubt that a patient with papillary carcinoma with local metastasis and no evidence of widespread disease should have radical surgery. It is also clear that a patient with follicular carcinoma should have a minimum of a total thyroidectomy in order to take away thyroid function so that distant metastases may possibly be controlled with radioactive iodine. Beyond this, however, the therapy of each case must be individualized.

A growing trend toward earlier surgical intervention and more radical surgery would seem to be a step in the right direction. Judging from the above comments it is evident that all enlargements of the thyroid gland, and particularly adenomatous goiters, should be viewed with suspicion. The results of treatment would seem to emphasize the need for a high index of suspicion and the performance of early surgery.

* In our hospital the 21 carcinomas were found among 378 thyroid adenomas operated upon, an incidence of 5.5% in patients that came to surgery. However, an unknown number had no surgery here.

Conclusion

Twenty-one patients with malignant disease of the thyroid gland were admitted to Milwaukee County General Hospital from 1940 through the first six months of 1955. The tumors have been classified as to microscopic appearance and biologic behavior. The high incidence of anaplastic carcinoma is attributed to the large number of older patients. A comparison between our series and others was made with regard to behavior of the various cell types. We have substantiated that well-differentiated tumors are much less malignant and offer a much better prognosis than the undifferentiated types; also, papillary carcinomas usually metastasize to local lymph nodes and can be resected, whereas follicular carcinomas, while they are relatively slow growing, metastasize widely via blood vessels. A few facts have been presented to help show that a universally accepted histologic classification of thyroid carcinomas is necessary for a more rational view of treatment.

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REFERENCES

1. Warren, S., and Meisner, W. A.: Tumors of the Thyroid Gland, Section 4, Nat. Res. Council Atlas of Tumor Pathology, Section 14, Fascicle 14, Washington, D. C., Armed Forces Institute of Pathology.
2. Pemberton, John de Jarnette, and Black, B. Marden: Cancer of the Thyroid, monograph edition, New York, American Cancer Society, 1954.
3. McDermott, William V., Jr., and others: Cancer of thyroid, J. Clin. Endocrinol. 14:1336–1354 (Nov.) 1954.
4. Martin, Hayes: Surgery of thyroid tumors, Cancer 7:1063–1099 (Nov.) 1954.
5. Horn, Robert C., Jr., and Ravdin, I. S.: Carcinoma of thyroid gland in youth, J. Clin. Endocrinol. 11:1166–1178 (Oct.) 1951.
6. Crile, G., Jr., and Hazard, J. B.: Relationship of age of patient to natural history and prognosis of carcinoma of thyroid, Ann. Surg. 138:33–38 (July) 1953.
7. Alexander, M. J.: Occurrence of thyroid cancer in San Francisco, New England J. Med. 253:45–51 (July) 1955.
8. Warren, S., Alvizouri, M., and Colcock, B. P.: Carcinoma of thyroid in childhood and adolescence, Cancer 6:1139–1146 (Nov.) 1953.
9. Sokal, J. E.: Occurrence of thyroid cancer, New England J. Med. 249:393–397 (Sept. 3) 1953.
10. Winship, Theodore, and Chase, W. W.: Thyroid carcinoma in children, Surg. Gynec. & Obst. 101:217–224 (Aug.) 1955.

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Doctors Plan War on Uterine Cancer

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CANCER of the uterus is the second most frequent female cancer and causes over 15,000 deaths yearly in the United States.

During recent years evidence has accumulated that cancer of this site probably has a latent period of some years' duration between its onset and later invasive or clinical stages and, if sought during this time, is subject to early detection and cure. Concurrently, the Papanicolaou smear has proved to be a reliable diagnostic aid capable of uncovering early uterine and other exfoliating cancer. If periodically performed on all adult women, it is a potential means for removing uterine cancer as an important cause of death.

The major deterrent to the wide use of the smear test as a preventive-detection procedure has been the involved physician and laboratory work load, as an estimated one hundred or more women must be screened to find the examinee harboring a previously undiagnosed malignancy. Hope for some easier, possibly multi-site, detection test has been held. However, there now is accepted medical recognition that the smear test *per se* probably is as simple, practical, and reliable a case-finding procedure as ever will be obtained for uncovering curable uterine cancer, and that the task remaining is to put it to a volume of use adequate to protect all women.

Within Wisconsin, efforts to do so are well under way with the medical societies of Buffalo, Dane, Green Lake, Jackson, Oneida, Polk, Sauk, Trempealeau, Vilas, and Waushara counties joining with the State Laboratory of Hygiene, the United States Public Health Service, and the State Board of Health in a ten-county-wide, three-to-five-year case-finding project. The plan provides for the obtainment of periodic smears within the family doctor's office on all women 20 years of age or over as part of regular visits and by special appointment. The specimens are sent to the State Laboratory of Hygiene for examination. Women's groups of these counties are being informed on this matter and encouraged to promote and seek periodic preventive examinations. There is every reason to believe that if nearly all women will avail themselves of this preventive medical care service, their doctors will soon remove cancer of the uterus as an important cause of death among them.

Beyond attempting to meet the immediate goal of preventing cancer deaths in Wisconsin, this demonstration project and its findings will serve as a pilot study for similar endeavors elsewhere in the United States. Epidemiological and other data for statistical studies are being maintained on punch cards for all specimens received by the laboratory. These data should particularly add to the knowledge of early disease, its incidence, progression rate, choice of treatment, and the time periods safely allowable between repeat smears in apparently normal women.

Wisconsin will derive considerable long-range benefit from the cytologist training phase of this program as the shortage of such personnel at local and higher levels is very acute. In addition, there should be a very substantial reduction in the time otherwise required for Wisconsin women to universally establish the practice of seeking periodic cancer prevention care. The establishment of this practice is very essential to any major reduction in uterine or other cancer deaths as the physician can neither prevent nor heal cancer in patients who do not come to him in time.

In recognition of the fact that the doctors in the above counties have undertaken both a large and very significant cancer control project, they are to be commended for their leadership and efforts to demonstrate that cancer of the uterus can be reduced to a minor cause of death in women of their counties, and eventually elsewhere.—A. L. VAN DUSER, *Director, Division of Cancer Control.*

Case Report of a Fatal Infection With Bacteroides Fragilis*

By ERNST M. FROEHLICH, M. D., and EDMUND W. SCHRUEMPF, M. D.

Milwaukee

Introduction

THE large group of gram-negative, anaerobic, nonsporulating bacilli, which do not have fusiform points, but rather rounded ends, was first summarized as the genus *Bacteroides* by Castellani and Chalmers.[1] So far there are 23 recognized species, which are listed in *Bergey's Manual of Determinative Bacteriology*.[2] Although the present arrangement in Bergey's Manual must be considered as tentative because many of these organisms have not been subjected to critical studies with identical tests and media, and also because there are relatively few cases reported in the literature, the importance of *Bacteroides* infections in humans must not be overlooked.[3-5] Several nonpathogenic strains of *Bacteroides* have been found in the human gastrointestinal tract and in the vagina.[6] There are even reports that in some instances *Bacteroides* outnumbered *Escherichia coli* in human colons.[7, 8] Spontaneous infections are known in animals such as rabbits, cattle, sheep, horses, and mules.[9] In these species *Bacteroides* produces necrotizing lesions of the skin as well as metastatic abscesses in joints, liver, lungs, and brain. Furthermore, specific infections ascribed to *Bacteroides*, such as foot rot and grease-heel, have been described in animals.[9] In humans mixed infections are the rule, usually with the production of localized abscesses in single organs such as the middle ear,[10-12] mastoid,[13] parotid,[14] tonsils,[15] brain,[16, 17] meninges,[18] pleura,[19, 20] lungs,[21] endocardium,[22] liver,[23, 24] intestines,[25] appendix,[26] urinary tract,[27, 28] and female genital tract.[29, 30] Generalized infections, however, such as septicemia,[31-33] puerperal sepsis,[34] or postabortive sepsis[35] are also reported.

The following case of infection with *Bacteroides* is reported in the interest of drawing attention to this rather little-known pathogen. We believe with Dack[3] that more cases of this nature would be discovered if the organisms were suspected by the clinician and searched for by the bacteriologist by use of routine anaerobic cultural methods when purulent material is submitted.

Case Report

A 51-year-old, white tavernkeeper, who was known as a heavy drinker and eater, was admitted to St. Luke's Hospital on March 9, 1955, to have surgical treatment of a large mass in the left scrotal sac. The past history revealed that the patient had been under constant medical treatment for digestive symptoms for 25 years. In June, 1954, he had been hospitalized for liver cirrhosis with hematemesis. In September, 1954, he had been readmitted because of his liver damage; at this time esophageal varices had been proved by x-ray studies. The patient had again been admitted in January, 1955, to have surgical repair of a large sliding left scrotal hernia. Shortly after the herniorrhaphy in January a hematoma had developed, had not been reabsorbed, finally had become encapsulated, and then had calcified.

Physical examination revealed an obese, moderately icteric, white male. The positive physical findings included scleral icterus, scattered spider angiomas over the chest, and marked hepatomegaly with the liver edge palpable just above the umbilicus in the midline. Superficial veins over the abdomen and lateral chest wall were dilated. A large mass, 8 by 5 by 5 inches, filled the left side of the scrotal sac.

Review of Laboratory Data From Previous Admissions

	June, 1954	September, 1954	March, 1955
Thymol Turbidity	11.5	9	11.5
Bromsulfalein Retention	20%	10%	------
Serum Bilirubin (1 min.)	1.2	0.4	.08
Serum Bilirubin (10 min.)	2.6	1.1	1.6
Prothrombin Time	41%	73%	46.2%
Serum Proteins	5.9	8.9	8.1
Albumin	3.5	5.2	3.1
Globulin	2.4	3.7	5.0
Hemoglobin	13 gm.	12.5 gm.	10.0 gm.
Alkaline Phosphatase	------	------	5.2
White Blood Cells	------	------	15,800

* This study was directed by William J. Blake, M.D., Assistant Director of Laboratories, St. Luke's Hospital, Milwaukee.

The removal of the scrotal hematoma was done without complications under spinal anesthesia on March 9, 1955. The days following surgery were uneventful except for development of low-grade fever. Terramycin orally was followed by a two-day period of diarrhea which responded to discontinuing the Terramycin. A drain which had been inserted through a stab wound into the scrotum during surgery was removed on the sixth day. During the following days the morning temperature was normal; however, the evening temperatures rose to 101 F. There was a considerable amount of bloody drainage. A transfusion of 500 cc. whole blood was administered on the tenth postoperative day (March 19, 1955). Shortly after the transfusion the patient developed shaking chills, but recrossmatch and studies of serum and urine showed no evidence of hemolytic reaction. Several times the scrotal wound was debrided and large amounts of blood clot and necrotic, foul-smelling tissue removed. The temperatures remained constantly high, averaging 100 to 101 F. in the morning and 102 to 103 F. in the evening. Large amounts of bloody, offensive-smelling fluid continued to drain from the operative wound. The subjective condition, however, was relatively satisfactory. On the twentieth day after the operation a temperature of 104 F. suddenly developed, accompanied by severe chills and profuse perspiration. Under aspirin medication the patient's temperature returned to normal for a short period, but on the next day a low-grade fever developed; this continued until the fortieth day. On the forty-first, forty-third, and forty-sixth postoperative days the temperature again rose as high as 105 F., associated with severe chills and profuse diaphoresis. Combiotic in a dose of 1 gm., streptomycin twice a day, and aspirin were administered and discontinued on the fiftieth postoperative day. The following day brought another fever spike (105 F.) with severe chills and pains in the left upper abdominal quadrant and the left chest. At the peak of this spike a blood sample was drawn and incubated under anaerobic and aerobic conditions. There was growth under anaerobic conditions, and the gram-negative, nonsporulating rods were tentatively identified as *Bacteroides*. Another fever spike occurred on the fifty-fifth day, on which date Chloromycetin therapy (250 mg., four times a day, for 3 days) was begun. The temperatures during the following days averaged 99 to 100 F. during the morning hours and about 101 F. in the evenings. Severe pains in the left upper abdomen appeared suddenly on the sixty-second postoperative day. The abdomen became extremely distended, tense, and tender; and the patient vomited large quantities of greenish fluid. Surgery was felt indicated, but the patient's extremely poor condition did not permit. A Levine tube relieved the patient somewhat and drained large amounts of bile-stained intestinal juice. There was another spell of chills on the sixty-sixth day, from which time on the patient appeared cold and clammy and became progressively more stuporous, finally expiring in coma on the eighty-first postoperative day.

At autopsy the peritoneal cavity contained approximately two liters of clear amber fluid. There was an extensive, patchy, fibrinopurulent exudate plastering loops of small bowel together, and two loops of proximal jejunum were prominently dilated. The pelvis contained approximately 2,000 cc. of thick, brownish-red-yellow pus separated from the general peritoneal cavity by a soft pyogenic membrane. Similar intraperitoneal pockets of smaller size were found between folds of the mesentery, and extensive subphrenic collections of pus were present bilaterally. The hilus of the spleen was adherent to the greater curvature of the stomach, and detailed examination of this region between the stomach and spleen showed several small abscess cavities which communicated with the left subphrenic abscess. The omentum was plastered to this region and indurated. In the gastric mucosa of the greater curvature adjacent to these abscesses was a shallow ulceration 2.5 cm. in diameter. Microscopic sections demonstrated the ulcer base to be coated by a peptic membrane of fibrin, polymorphonuclear leukocytes, and necrotic debris. The underlying muscularis was replaced by edematous granulation tissue rich in macrophages, polymorphonuclear leukocytes, lymphocytes, and newly formed capillary vessels, and containing a sinus tract bordered by granulation tissue.

The liver weighed 2,000 gm. and showed typical gross and microscopic evidence of portal cirrhosis. In addition, there were

gastric and esophageal varices, gynecomastia, and fibrocongestive splenomegaly (700 gm.).

The left pleural cavity was filled with soupy, yellowish-brown, seropurulent material; and the left lung was collapsed and atelectatic, and its pleural surface was covered with a shaggy fibrinopurulent exudate.

The scrotum was extensively dissected at autopsy, and the left side was found to be filled with dense, fibrous, and granulation tissue. There was no gross or microscopic evidence of abscess formation or residual infection.

Focal pneumonitis of a terminal nature, moderate right hydrothorax, and chronic cholecystitis with cholelithiasis completed the postmortem picture. The brain was not examined.

The bacteriological examination of specimens obtained at the autopsy revealed:

1. **Ascitic Fluid:** Hemolytic staphylococci, *Escherichia coli,* and apathogenic sporeformers.

2. **Subphrenic Abscess:** Hemolytic staphyloccoci, *Escherichia coli,* gram-positive sporeformers. A gram-negative, nonsporulating rod, with the same appearance as the later cultivated *Bacteroides fragilis,* was seen in Gram stains of pus and in thioglycollate cultures, but was lost due to subsequent overgrowth by *E. coli* before anaerobic isolation could be accomplished.

3. **Pelvic Abscess:** Same as subphrenic abscess, except overgrowth was by *Proteus vulgaris.*

4. **Bowel Contents:** Normal bowel flora and hemolytic staphyloccoci.

5. **Left Pleural Cavity:** *Bacteroides (fragilis)* in pure culture.

6. **Blood Obtained from Heart:** Pure culture of *Bacteroides (fragilis).*

Bacteriology

As shown above, three cultures positive for *B. fragilis* were available for study: (1) Blood culture of fifty-first postoperative day; (2) Heart's blood post mortem, and (3) Left pleural cavity. Since all showed the same growth characteristics, they will be described together.

The following method was used to culture and study the organisms. The primary inoculation in the case of the blood culture during life was into tripticase soy broth anaerobically with added carbon dioxide; otherwise it was on thioglycollate broth, and isolation was accomplished anaerobically on 5% blood agar. Anaerobic conditions were accomplished by means of a Brewer jar in which the atmospheric air was replaced with nitrogen. The evacuation and replacement process was repeated 10 times at atmospheric pressure to insure complete elimination of all oxygen (tested with pyrogallol and potassium hydroxide). The incubation temperature selected was 37 C., duration 24 hours. Although there was growth on nutrient agar, best growth was obtained on fresh blood agar, which therefore was used for all studies.

The organism cultured was a 0.8 to 1.2 mu long, 0.2 to 0.3 mu wide, gram-negative, obligatory anaerobic, nonmotile, pleomorphic rod. It was slightly expanded at the poles, and they stained more intensively. The arrangement of the rods was irregular and random, with no cellular grouping. On blood agar and on all other solid media used, the organisms produced mucoid, smooth, whitish-gray, convex, concentric, sharply defined colonies averaging about 0.5 mm. in diameter. Hemolysis or other hemoglobin changes were not observed. In liquid media such as thioglycollate or nutrient broth, the organisms formed a cloudy, turbid growth with a fine, whitish deposit at the bottom of the test tubes. They formed neither indol nor hydrogen sulfide, nor did they reduce nitrates to nitrites. Gas production from peptone was noticed. Litmus milk was not coagulated in 14 days. Sugar fermentation studies revealed acid formation from xylose, glucose, fructose, galactose, lactose, succrose, maltose, raffinose, starch, insulin, and dextrin. There was no acid from mannitol, arabinose, and trehalose. The strain was not pathogenic for white rats either by subcutaneous or intraperitoneal routes. The patient's serum obtained the day before he died agglutinated organisms from all three sources equally at a titer of 1:1,600. There was no agglutination by control serum. According to the key in Bergey's Manual and considering the biological and cultural characteristics, the organism was classified as *B. fragilis.*

A sensitivity test proved susceptibility to the following antibiotics (tested with standard Bacto discs on blood agar plates):

Chloromycetin inhibition around disc containing 10 mcg.
Terramycin inhibition around disc with 30 mcg., none with 10 mcg.
No inhibition with:

Achromycin	1 mcg.
Aureomycin	30 mcg.
Dihydrostreptomycin	10 mcg.
Bacitracin	10 units
Furadantin	10 mg.

Discussion

That the course of this case was dominated or largely influenced by infection with *B. fragilis* seems proved beyond reasonable doubt. The presence of a pure growth of the organism in both antemortem blood culture and postmortem heart's blood, together with the presence of the organism in the various abscesses cultured at autopsy, positively relates the organism to the infectious lesions. The consistently high agglutinin titer to organisms isolated from the different sources is strong corroboration that *Bacteroides* was more than a terminal saprophytic invader.

It seems likely, in view of the recovery of *Bacteroides* at the height of a fever spike, that the organism was responsible for some, if not all, of the prolonged febrile course. The terminal event, proved by autopsy to have resulted from penetration of a gastric ulcer, is difficult to relate to systemic infection by any bacterium. A more plausible explanation might be that the penetrating ulcer was sealed off by spleen and omentum but in the process an area of decreased tissue resistance was formed which allowed *Bacteroides* a focus for proliferation within the abdomen.

Although the most likely portal of entry of *Bacteroides* in this case would seem to be the scrotal wound, cultures made of draining pus during life were not treated anaerobically and proof is therefore lacking. Alternate possibilities might be infection via blood transfusion or entry through the intestinal lymphatics.

We believe this case illustrates the importance of routine anaerobic culturing of pus and exudates. It is impossible to negate the presence of pathogenic anaerobic organisms and consider pus or other material as "sterile" because no growth is obtained aerobically. Dack[3] at the University of Chicago examined 5,180 specimens sent in for routine examination and published a profound paper as early as 1940, demonstrating that not less than 4% of all cases showed different species of *Bacteroides*, alone or associated with other pathogenic organisms. Had the diagnosis been made and its significance appreciated in our case prior to the onset of septicemia and hematogenous spread of the infection (a complication which is not too uncommon),[31-33] the outcome might have been altered for the better by an adequate course of Chloromycetin, proved effective *in vitro*.

Summary

1. A case of systemic infection by *Bacteroides fragilis* is reported. The infection complicated a scrotal operation in a patient with cirrhosis of the liver.

2. The bacteriologic diagnosis of *Bacteroides* infections is discussed, and the importance of routine search for the organism in exudates by the use of anaerobic methods is emphasized.

St. Luke's Hospitals.

The authors wish to acknowledge the assistance of Dr. Henry Twelmeyer, the attending physician in the case discussed.

REFERENCES

1. Castellani, A., and Chalmers, A. J.: Manual of Tropical Medicine, ed. 3, New York, William Wood & Company, 1919, p. 959.
2. Breed, R. S., Murray, E. G. D., and Hitchens, A. P.: Bergey's Manual of Determinative Bacteriology, ed. 6, Baltimore, Williams & Wilkins, 1948.
3. Dack, G. M.: Non-sporeforming anaerobic bacteria of medical importance, Bact. Rev. 4:227–259 (Dec.) 1940.
4. McVay, L. V., Jr., and Sprunt, D. H.: Bacteroides infections, Ann. Int. Med. 36:56–76 (Jan.) 1952.
5. King, A. B., Conklin, S. D., and Collette, T. S.: Bacteroides infections: report of 2 cases unsuccessfully treated with antibiotics, Ann Int. Med. 37:761–767 (Oct.) 1952.
6. Weiss, J. E., and Rettger, L. F.: Gram-negative Bacteroides of intestine, J. Bact. 33:423–434 (April) 1937.
7. Lewis, K. H., and Rettger, L. F.: Non-sporulating anaerobic bacteria of intestinal tract; occurrence and taxonomic relationships, J. Bact. 40:287–307 (Aug.) 1940.
8. Misra, S. S.: Note on predominance of genus Bacteroides in human stools, J. Path. & Bact. 46:204–206 (Jan.) 1938.
9. Smith, D. T., and others: Zinsser's Textbook of Bacteriology, ed. 10, New York, Appleton-Century-Crofts, Inc., 1952.
10. Newhart, H.: Report of unusual bacterial findings in fatal case of chronic otitis media with complications, Laryngoscope 49:1024–1030 (Oct.) 1939.
11. Kapsenberg, G.: Otitis media associated with septic conditions caused by Bacteroides funduliformis, Nederl. tijdschr. v. geneesk. 90:890–891 (July 27) 1946.

12. Verdan, C.: Les pyémies à Bacillus funduliformis, Rev. méd. de la Suisse Rom. 56:751–756 (Oct. 25) 1936.
13. Schmidt, Max: Ueber funduliformis-mastoiditis, Schweiz. med. Wchnschr. 77:1247–1249 (Nov. 29) 1947.
14. Heck, W. E., and McNaught, R. C.: Periauricular bacteroides infection, probably arising in parotid: report of case, J.A.M.A. 149:662–663 (June 14) 1952.
15. Lemierre, A., and Moreau, R.: Un cas de septicopyohémie postangineuse à "Bacillus funduliformis" terminé par la guérison, Bull. et mém. Soc. méd. d. hôp. de Paris 52:912–918 (June 8) 1936.
16. Sedallian, P., and others: Septicopyohémie à bacille "Funduliformis" avec abcès du creveau stérilisé par la pénicilline, Bull. et mém. Soc. méd. d. hôp. de Paris 64:351–353 (March 5–19) 1948.
17. Steen, E., and Thjøtta, Th.: Studies on bacteroides; V. Cerebral abscess caused by bacteroides serpens, Acta path. et microbiol. Scandinav. 27:851–864, 1950.
18. Ballenger, J. J., Schall, L. A., and Smith, W. E.: Bacteroides meningitis—report of case with recovery, Ann. Otol. Rhin. & Laryng. 52:895–901 (Dec.) 1943.
19. Brunner, Werner: Ueber bacillus funduliformis—Infektionen unter bisonderer Berücksichtigung der pleuralen Erkrankungsformen, München. med. Wchnschr. 84:2032–2036 (Dec. 17) 1937.
20. Suessmann, Ph.O., and Dicker, H.: Pleuraempyem durch Fusobakterien, Muench. med. Wchnschr. 85:583–584 (April 22) 1938.
21. Bruining, M.: Pulmonary abscess due to Bacteroides funduliformis; case, Nederl. tijdschr. geneesk. 97: 1201–1203 (May 9) 1953.
22. Rantz, L. A.: Bacteroides endocarditis; report of case successfully treated with Terramycin, J.A.M.A. 147:124 (Sept. 8) 1951.
23. Rubin, S. H., and others: Aureomycin treatment of recurrent cholangitis with liver abscesses due to Bacteroides funduliformis, Ann. Int. Med. 35:468-475 (Aug.) 1951.
24. Goodnough, C. F.: Liver abscess caused by Bacteroides funduliformis, Am. J. Surg. 53:506–508 (Sept.) 1941.
25. Picard, Perrin, and Franck: Septicémie à "Bacillus fragilis" avec hémorragie intestinale et abcès du foie, Bull. et mém. Soc. méd. d. hôp. de Paris 52:1239–1241 (July 20) 1936.
26. Veillon, A., and Zuber, A.: Sur quelques microbes strictement anaérobies, Arch. med. exper. 10:517-545 (July) 1898.
27. Schulte, T. L.: Bacteroides and anaerobic streptococci in infection of urinary tract: report of case, Proc. Staff Meet., Mayo Clin. 14:536–538 (Aug. 23) 1939.
28. Worms, R., and Pecker, J.: Un cas de septicémie à Bacillus fragilis avec détermination rénale, Semaine hôp. Paris 26:4081–4084 (Oct. 22) 1950.
29. Clark, C. E., and Wiersma, A. F.: Bacteroides infections of female genital tract, Am. J. Obst. & Gynec. 63:371–380 (Feb.) 1952.
30. Hartl, H.: Gynäkologische Monoinfektionen mit Bacillus funduliformis, Geburtsh. u. Frauenh. 11:155–162 (Feb.) 1951.
31. Thompson, L., and Beaver, D. C.: Bacteremia due to anaerobic gram-negative organisms of genus Bacteroides, M. Clin. North America 15:1611–1626 (May) 1932.
32. Ernst, O., and Hartl, H.: Über Funduliformis—Septikämien, München. med. Wchnschr. 93:1213–1216 (June 15) 1951.
33. Hartl, H.: Septikämie durch Bacillus funduliformis, Ztschr. Geburtsh. u. Gynäk. 134:52–62, 1950.
34. Delbove, P., Elichc, J., and Nguyen-van-Huong: Bactériémie post partum à Bacillus fragilis, Bull. Soc. path. exot. 32:126–129, 1939.
35. Lemierre, A., Reilly, J., and Daum, S.: Septicémie à "Bacillus fragilis," Bull. et mém. Soc. méd. d. hôp. de Paris 54:436–439 (March 21) 1938.

FISKE ESSAY ON INFERTILITY

The trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce as the subject for this year's dissertation "The Present-Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

The first-prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held at the Hotel William Penn, Pittsburgh, May 6–9, 1957.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee
F. E. SHIDEMAN, M. D., University of Wisconsin, Madison

Tranquilizing Agents

The field of psychopharmacology and the clinical application of new drugs uncovered as a result of screening procedures in this area has become an extremely lucrative business. Very recently one representative of the pharmaceutical industry conservatively estimated that the gross receipts from the sale of tranquilizing agents during the current year would approximate one hundred and thirty-five million dollars. The spate of new drugs of this type is partly the result of the competition which presently exists among the producers of medicinal substances and their productive marriage with the synthetic organic chemist. Wide and at times uncritical application has been an added impetus. The third major factor in producing this large-scale operation stems from the overenthusiastic publicity which the lay press is wont to give to any new discovery in the field of medical science. The physician, in spite of a fundamentally objective attitude in relation to application of new treatments, may not always find it feasible to stick to old reliables because he himself is perennially hopeful that something better has indeed been found.

The present picture with regard to the tranquilizing drugs or ataraxics (from ataraxia meaning calmness untroubled by mental or emotional excitation) is not uncommonly seen when any dramatic new drug is introduced. After skeptical acceptance a tidal wave of enthusiasm follows. It is especially during this phase that every practicing physician should put forth an additional effort in attempting to be truly objective in terms of treatment. The situation is not unique in the case of the drugs under discussion; your author merely wishes to advocate a bit of caution and suggest that some benefit might be gained from past experiences. All chemical agents which are utilized for therapeutic purposes are potentially hazardous under the appropriate circumstances. In some cases it takes longer for undesirable effects to become apparent than in others. Almost fifty years elapsed between the introduction of barbital and the time barbiturates were realized to possess addiction potentialities.

Most of the tranquilizing agents, when employed wisely, are of value and usually without serious toxic effects. The phenothiazine derivative, chlorpromazine, can produce an obstructive type of jaundice, which ordinarily is mild but can be serious, and the occurrence of agranulocytosis has been reported. The potentiality of serious reaction, although rare, demands that patients should be selected with care when the drug is used in full dosage for an extended period of time, and its use should be discontinued immediately on appearance of toxic effects unless the advantages to be gained by continued use are immediate and of real importance. The appearance of even less severe toxic effects; *e.g.*, loss of appetite, skin rashes, gastrointestinal disturbances, anemia, leukopenia, is sufficient justification for discontinuance of the drug. Still greater caution should be exercised in the case of promazine (Sparine), with which extremely limited experience has been realized.

Rauwolfia serpentina, its partially purified derivative (Rauwiloid), and the crystalline compounds derived from the plant have been employed successfully to reduce emotional tension. A number of the undesirable effects of these substances, as well as of other tranquilizing agents, have been presented and discussed by Friend and McLemore.[1] Most of the manifestations, as these authors point out, are mild, but occasional complications may arise. Small daily doses may reactivate an old, or result in the formation of a new, peptic ulcer. Colonic irritation and diarrhea have given rise to signs and symptoms which have been mistakenly related to an acute condition in the abdomen, and surgical intervention has followed.

Other ataraxics; *e.g.*, meprobamate (Miltown, Equanil) and azacyclonol (Frenquel), have not received sufficient clinical trial to allow an assessment of their merits and hazards. The status of all such agents with respect to long-term or indiscriminate usage cannot be established at the present time. In connection with the desired therapeutic action of certain of the tranquilizers, there appears to be a goodly amount of reasonable skepticism as to whether or not they have any direct effect upon the central nervous system. The placebo component without doubt plays a considerable role in determining the success of the response.

We have seen mental depression result from protracted administration of these drugs, and there is more than a suggestion that suicides have followed. In the absence of definitive information it is wise to proceed with caution. Symptomatic benefit is the best that we can expect to realize from their employment, and this will have to be weighed against the possible hazards of the unknown.—F. E. SHIDEMAN, M. D.

REFERENCE

1. Friend, D. G., and McLemore, G. A., Jr.: Some abuses of drugs in therapy, New England J. Med. 254:1223–1231 (June 28) 1956.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association, which will be held in the Hotel Statler, New York, May 28, 29, and 30, 1957, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the association.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATION

The next scheduled examination (Part I), written, and review of case histories for all candidates will be held in various cities of the United States and Canada and in military centers outside the continental United States on Friday, February 1, 1957, at 2 p.m.

Candidates must submit case reports to the office of the secretary within 30 days of being notified of their eligibility to Part I.

Request for re-examination in Part II must be received prior to February 1, 1957.

Current bulletins may be obtained by writing to:

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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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Clinicopathologic Conference

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: F. J. Glassy, M. D.

Report of a Case

(From Milwaukee County General Hospital)

The patient was a 65-year-old, white, adult female who entered Milwaukee County General Hospital because of inability to walk and progressive weakness. In 1936 she was told that she had an enlarged spleen, but she had no complaints and received no therapy. A tumor of the right ovary was removed in this hospital in 1943. At the same time a diagnosis of polycythemia vera was made, and the patient was treated with phlebotomies. In 1945 examination of the patient revealed a hypertension of 230/130, moderate hepatomegaly, marked splenomegaly, and cardiomegaly.

Painful swelling of the joints of her hands and feet developed in 1946, and the uric acid was elevated to 5.5 mg.%. In 1947 the patient became aware of excessive warmness of her hands and face, and she stated that she usually slept with only a sheet as a cover. Treatment consisted of phlebotomies and phenylhydrazine.

In the years that followed she continued to have complaints of weakness and joint pain, with additional symptoms of dyspnea and peripheral edema in later years. Treatment consisted of phlebotomies, x-ray treatment to the spleen, colchicine, and digitalis. Phlebotomies became unnecessary about 1949 because the hemoglobin and red blood cell count remained at normal levels. The highest of several uric acid determinations in 1950 was 9.6 mg.%. A bone marrow biopsy in 1950 showed hypercellularity with many eosinophilic granulocytes, most of which were myelocytes; increased megakaryocytes, some of which were atypical; and areas of fibrosis.

The patient's last admission was in 1952, at which time she complained of weakness and extreme joint pain. Pertinent physical findings included: blood pressure 166/70; distention of neck veins; nodular goiter; cardiomegaly; enlargement of the spleen below the iliac crest; enlargement of the liver below the umbilicus; and red, tender swelling of joints of the hands and feet. The hospital course was marked by progressive dyspnea with tachycardia and rales in the lungs which persisted despite the usual treatment for heart failure. On the fifty-second hospital day the patient was noted to have petechiae over the ankles, in the conjunctivae, and beneath the tongue. At that time the platelet count was 165,000, the Rumpel-Leede test was positive, and the prothrombin time was 34.5% of normal. A blood culture two days before death was positive for nonhemolytic streptococci. The

	7-1-43	7-26-43	4-16-45	1-7-47	7-17-50	6-12-52	6-19-52
Red Blood Cells	7,240,000	7,490,000	5,270,000	6,590,000	4,840,000	3,590,000	5,230,000
Hemoglobin	16.5 gm.	17.5 gm.	16 gm.	18.5 gm.	12.5 gm.	9.9 gm.	12.7 gm.
Hematocrit	61%		52%	58%	38%	27%	
Color Index	0.74	0.77	1.0	0.88	0.84	1.0	0.87
Mean Corpuscular Hemoglobin	23	23	30	28	26	28	24
Mean Corpuscular Hemoglobin Concentration	27		31	32	33	37	
Mean Corpuscular Volume	84		99	88	79	75	
White Blood Cells	15,300	15,150	10,700	15,550	19,000	21,350	65,800
Stabs	25%	13%	23%	20%	63%	27%	27%
Segmented Neutrophils	60%	68%	56%	59%	16%	56%	60%
Eosinophils	4%	5%	1%	3%	3%		3%
Basophils	1%	2%	4%	1%	3%	4%	
Lymphocytes	10%	7%	11%	12%	1%	4%	3%
Monocytes		4%	1%	5%	5%	5%	2%
Neutrophilic Myelocytes		1%	3%		3%	2%	4%
Neutrophilic Promyelocytes			1%		6%	Juvenile 2	1%
Normoblasts	1/100 white blood cells		1/100 white blood cells		1/100 white blood cells	1/100 white blood cells	1/100 white blood cells
Reticulocytes	4.2%		3.3%			4.5%	
Platelets (direct method)			106,000	216,000		165,000	
Erythrocyte Sedimentation Rate				1 mm.		20 mm.	
Basal Metabolic Rate			+36				

patient's temperature was normal until the sixtieth hospital day, at which time it was elevated to 101 F., thereafter returning to normal. The course was one of progressive deterioration with mental confusion until the patient's death on the eighty-first hospital day.

During the last hospitalization, the nonprotein nitrogen rose from 48 to 76 mg.%. The urine showed 3 to 4+ albumin, an increase from the 1 to 2+ which had been present since 1945. The direct Coombs' test was negative and the icteric index normal. Bone marrow aspirates throughout the years showed hypercellularity with no specific morphologic diagnosis.

Dr. A. V. Pisciotta read the protocol, and asked **Dr. J. L. Marks** to discuss the x-ray findings at this time.

Doctor Marks: This is one of the original chest films. It shows generalized cardiac enlargement, predominantly in the transverse diameter, with prominence in the region of the left ventricular contour and rounding of the left ventricular contour. The aorta is slightly tortuous and elongated. Both hilar regions show evidence of hilar congestion, and the interstitial markings radiating out into the peripheral portions of both lung fields reveal evidence of pulmonary congestion. There is no evidence of fluid present on this original film. The costophrenic sulci bilaterally are sharply outlined. There is an incidental calcification in the paratracheal region consistent with calcification within the thyroid gland.

This next study shows the barium enema. The region of the rectum is normal. In the descending colon there is a marked depression of the splenic flexure of the large bowel. Ordinarily there is free mobility of the hepatic flexure, but the splenic flexure is usually a fixed structure in the left upper quadrant secondary to the phrenocolic ligament. There is a marked downward depression of the splenic flexure secondary to a huge mass, which in this particular case is a splenomegaly.

The evacuation film likewise shows a marked downward depression of the splenic flexure with compression of the transverse colon in the region of the enlarged spleen. There is no evidence of further abnormality in the remaining portions of the large bowel.

Doctor Pisciotta: Doctor Greenwalt, would you please discuss this case?

Dr. T. J. Greenwalt: This was a very interesting and classical case, at least in the beginning. The first thing in the history that strikes one is the palpable spleen in 1936. With the diagnosis of polycythemia made seven years later in 1943, we have to assume that the patient probably also had polycythemia in 1936. Sixteen years is a long survival time for a patient with polycythemia. The usual period given is six to seven years. Lawrence reports that with radioactive phosphorus therapy patients frequently survive over 10 years. Occasionally the course exceeds 20 years even without radioactive phosphorus therapy.

It would be interesting to know what the tumor of the right ovary was. I was just wondering if the patient might have had a dermoid cyst of the right ovary because such cysts are sometimes associated with hemolytic anemia.

She had hypertension and splenomegaly when the diagnosis of polycythemia was made in 1943. Although this case does not fit into the classification of Gaisböck's syndrome because of the presence of splenomegaly, I mention it only to stress that in my opinion subdivision of polycythemia vera into various syndromes adds unnecessary complexity.

Painful swelling of the joints was associated with a uric acid of 5.5 mg.% in 1946. Of more significance is the high uric acid level of 9.6 mg.% in 1950. The association of elevated uric acid levels with chronic myelocytic leukemia and polycythemia vera is not uncommon. But the actual clinical syndrome of gout is somewhat unusual. We don't too frequently see actual joint manifestations, and I am pretty certain that the patient had gouty manifestations. I think I remember this patient. She was given colchicine and experienced dramatic relief. From the therapeutic trial standpoint, this seemed like a true case of gout, only it was associated with polycythemia vera. The patient had the typical big toe pain and was unable to sleep when she had any type of cover on because the joints were so tender.

In 1947 she became aware of excessive warmness of her hands and face. This brings to mind erythromelalgia, Weir Mitchell's

disease. In polycythemia the rubor and the burning pain are apt to be unilateral, but in this patient they seem to have been bilateral. I just mention this to remind the younger men that there is such a syndrome as erythromelalgia or Weir Mitchell's disease.

Treatment with phlebotomies was the accepted therapy for a long time. It still is good therapy. I question the advisability of x-ray therapy to the spleen in polycythemia vera. X-ray therapy to the long bones has been used effectively. The patient must have had evidences of congestive failure before because she had received digitalis prior to the present hospitalization. The hemoglobin and red blood cell count from 1949 on remained at normal levels, and further phlebotomies were not required. Of course, the diagnosis of polycythemia vera in this protocol was not definitely established because there was never an oxygen saturation study or a blood volume study done. However, a hematocrit of 61 in 1943 is quite significant. Polycythemia may be relative, or it can be secondary polycythemia. Thus, we can not be absolutely sure that this patient had polycythemia vera, but I am assuming so. I think we are safe in this assumption because she did respond to phlebotomies over a number of years and then after 1949 didn't require any more of them.

When she was admitted to the hospital in 1952, her blood pressure no longer was hypertensive—at least the diastolic pressure was down to 70, and she had a high pulse pressure of 96. The spleen was quite huge, down to below the iliac crest. The liver was enlarged considerably, but perhaps this was due in part to the congestive failure. Interesting developments appeared during the last hospital stay which make us pause. On the fifty-second hospital day, petechiae were noted. This was probably not due to thrombopenia because the platelet count was 165,000. The Rumpel–Leede test was positive. The prothrombin time was 34.5% of normal. I wonder if the patient was receiving Dicumarol; it would be important to know that. One blood culture was positive for nonhemolytic streptococci. The patient had no fever, except on one day, the sixtieth hospital day, when her temperature rose to 101 F.; it thereafter returned to normal.

Doctor Pisciotta: There is no history of Dicumarol treatment.

Doctor Greenwalt: The patient's course was progressively downhill, with mental confusion; and she died on the eighty-first hospital day.

The blood cell count in 1945 probably was taken after several phlebotomies had been performed. Some leukocytosis, 4% basophils, a few immature myeloid cells, and one normoblast per 100 white blood cells were present. The reticulocyte count was slightly elevated, 3.3%. Strangely enough, the platelet count was reported as 106,000. We would expect this count to be normal or elevated in polycythemia vera.

In 1947 the hematocrit was 58%, and the hemoglobin and red blood cell count were elevated. The leukocytosis was more marked, but there were no immature cells present in the peripheral blood stream. It is interesting to note that the sedimentation rate was 1 mm. We know that after 1949 the patient had no further phlebotomies, and the blood cell count in July, 1950, was within fairly normal limits for a female. The hematocrit was 38%, and the leukocyte count was higher than it had ever been before. If one studies these laboratory data, he will see that this patient had an absolute lymphopenia all through her course. It is interesting to note, also, that at the last count she had a reticulocyte elevation to 4.5%. We have a patient who, I am assuming, had polycythemia rubra vera associated with an elevated uric acid and the clinical gout syndrome.

What happened to her after 1949? Was she developing myelofibrosis, which we know can be a complication of polycythemia vera? The picture isn't quite good enough for us to conclude that this was true, although there is some evidence. There wasn't really a good leuko-erythroblastic picture for myelofibrosis. The patient did have a very huge spleen, much larger than that usually seen in patients with polycythemia. She had a 4.5% reticulocyte count. Or was this just "burnt-out" polycythemia? Was she going into a hypoplastic phase? We also have to think of the possibilities of chronic myelocytic leukemia or even acute myeloblastic leukemia. The most likely diagnosis is myelofibrosis secondary to polycythemia vera. Why did the patient have the 34.5% prothrombin time, the purpura, and the positive blood culture? Did she develop subacute bacterial endocarditis or a mycotic aneurysm terminally?

Doctor Pisciotta: Thank you, Doctor Greenwalt. Does anyone have any questions or comments to make?

Dr. B. T. Heffernan: Have you ever seen a gouty kidney develop in a patient with polycythemia?

Doctor Greenwalt: No, I haven't.

Doctor Pisciotta: I don't remember having seen a gouty kidney in polycythemia vera.

Doctor Heffernan: In gout there are deposits of uric acid in the kidney. I am just wondering what the patient had, with 4+ albumin and with evidence of renal failure terminally.

Doctor Greenwalt: I deliberately overlooked that because I assumed that it was fairly obvious that an old lady with a nephrosclerotic kidney and hypertension might have prerenal azotemia with congestive failure.

Dr. D. W. Barrow: What is the effect of colchicine on the blood picture?

Doctor Greenwalt: I don't know of any effect of colchicine on the peripheral blood picture.

Doctor Pisciotta: It is not the function of the moderator to discuss the case, but I should like to point out two problems that occurred in this case that may be applicable to all cases of polycythemia vera. The first has to do with the natural course of the disease, the second with therapy.

The relationship of polycythemia vera to other myeloproliferative diseases is well illustrated by this case. The natural course of polycythemia may be interpreted in one of two ways, depending upon whether one wishes to consider the disease as a separate disorder affecting only the erythrocytic system or as one of a group of generally related disorders, with their common denominator as proliferation of medullary elements, which may change, one into the other, during the long natural course. I would like to recommend to you a very interesting article by Dameshek[1] in which he discusses the natural course of polycythemia vera over a period of 20 years. His way of thinking centers about the unitarian theory of myeloproliferative diseases, which lumps polycythemia vera, chronic granulocytic leukemia, myelofibrosis with myeloid metaplasia, and erythroleukemia into one large group representing different qualitative or quantitative responses to the same basic growth stimulus upon the medullary tissues. Polycythemia vera results when the stimulus has affected the erythrocytes as well as the precursors of the granulocytes and platelets. Chronic granulocytic leukemia may result from stimulation of all the white blood cell forming tissues; myelofibrosis with myeloid metaplasia may arise from excessive stimulation of fibrous and reticulum tissue and from overgrowth of myeloid cells and megakaryocytes in the fixed tissues, while erythroleukemia (Di Guglielmo's syndrome) may come from neoplastic proliferation of erythrocyte precursors. According to the unitarian concept, it is not uncommon for one of these diseases to change into another during its course. Thus, polycythemia vera, after many years, may terminate as granulocytic leukemia, erythroleukemia, or myelofibrosis.

Because of these dynamic changes, the clinical study of the natural course is extremely important as the terminal morphologic changes represent only a brief static episode in the long history of a disease.

On the other hand, some clinicians have found it most logical to "split" polycythemia vera from the other bone marrow diseases and to look upon it as a completely separate entity. From a morphologic point of view, there is usually very little difficulty in distinguishing between polycythemia vera and chronic granulocytic leukemia. This distinction is of importance from the standpoint of therapy. For example, Myleran, which is so effective in the treatment of chronic granulocytic leukemia, has no place in the therapy of polycythemia vera. Most recently, important differences in the chemical composition of leukocytes from the various myeloproliferative states have been described by Valentine[2] and his co-workers. It has been shown, for example, that the alkaline phosphatase content of a given number of leukocytes is significantly higher in infectious leukocytosis and in polycythemia vera than it is in chronic granulocytic leukemia.

While it is generally agreed that a permanent cure or definitive therapy is not yet available, the proper place of irradiation in the treatment of polycythemia vera has not yet been defined. Radioactive phosphorus has

generally provided the longest and most predictable remissions, but it has been objected to by some who say that this substance actually predisposes to a leukemic transformation. Whether this is actually true, or whether leukemia as a part of the natural course of polycythemia will occur in a certain number of cases regardless of therapy, cannot be stated following limited statistical experience with this disease.

To summarize this case briefly, it was a presentation of the long history of a woman with polycythemia vera who had received x-ray therapy to the spleen and died with a syndrome resembling that of myelofibrosis with myeloid metaplasia or chronic granulocytic leukemia.

Doctor Pisciotta: Doctor Glassy, would you please tell us about the autopsy findings?

Dr. F. J. Glassy: The ovary removed at surgery showed a benign papillary cystadenoma. When the abdominal cavity was opened at the time of autopsy, the spleen was noted to be extremely huge in the left upper quadrant and to be displacing many of the contents. It weighed 2,100 gm. and was smooth, firm, and red-purple. No areas of infarction were seen throughout the parenchyma. The cut surface was smooth and dark red with predominance of the lymphoid follicles. Except for a moderate number of dull pink nodes in the mesentery of the small bowel, the lymph nodes were not enlarged. The tracheal, bronchial, and mediastinal lymph nodes showed only a moderate degree of anthracosis. The liver was markedly enlarged and weighed 3,000 gm. It had a relatively smooth capsule; and throughout the parenchyma were many minute areas of pale yellow mottling. The gallbladder and bile ducts were not abnormal. The bone marrow of the sternum was brown-red, soft, and gelatinous with very few trabeculae present. The vertebral marrow was pale and moderately soft with trabeculae less prominent than usual. The heart showed only a moderate degree of myocardial hypertrophy with brown degeneration, and it weighed 550 gm. The valves were not unusual. The lungs were edematous but otherwise not unusual. The gastrointestinal tract, kidneys, and internal genitalia were without unusual features.

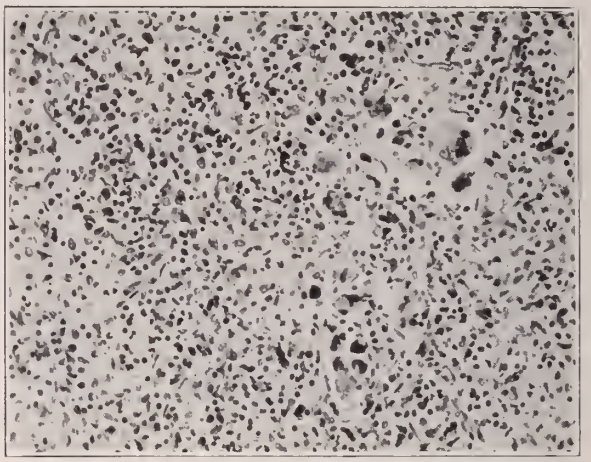

Fig. 1—Spleen. The thickening and prominence of the pulp cords, as well as the pleomorphic picture consisting of myelocytes, stem cells, and atypical megakaryocytes, are shown. The edge of a lymphoid follicle can be seen in the right upper corner. Hematoxylin and eosin stain, X 230.

The microscopic findings in this case showed many interesting features. Throughout the spleen and liver were areas of very extensive myeloid metaplasia with predominance of young stem or blast cells, many myelocytes, and large numbers of prominent megakaryocytes, many of which were quite atypical (fig. 1). A significant number of the myelocytes were eosinophilic. The bone marrow was very cellular, with no areas of fat remaining. The proliferation in the marrow consisted of young myeloid cells with a predominance of stem or blast cells too young to precisely classify and numerous atypical megakaryocytes (fig. 2) such as those noted in the spleen and liver. In the bone marrow mild diffuse fibrosis, with an increase in reticulum, was noted; this also had been present when a biopsy was done in 1950. Some of the reticulum fibers were intimately associated with megakaryocytes. Few foci of nucleated red blood cells were present in the spleen, liver, and bone marrow. There was no great distortion of the nodal or splenic architecture. Myeloid metaplasia, although not a prominent feature in the lymph nodes, was easily discernible. Other than myeloid metaplasia, the spleen showed some of the lymphoid follicles to be smaller than usual, perhaps due to extreme cellularity of the surrounding red pulp. The pulp cords were wider and more prominent than usual, partly due to proliferation of the reticulum as well as to proliferation of myeloid cells, which were also numer-

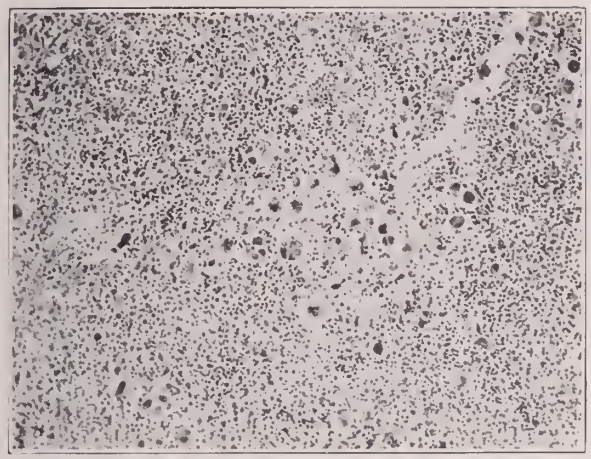

Fig. 2—Bone marrow. The hypercellularity, with many young myeloid cells and prominent atypical megakaryocytes, can be noted. Hematoxylin and eosin stain, X 115.

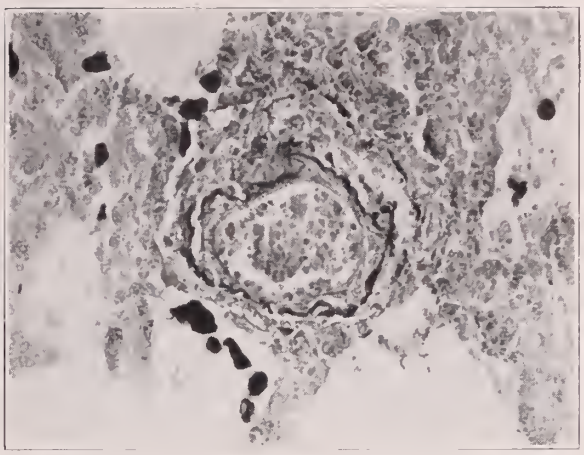

Fig. 3—Lung. In this vein the elastic fibers with deposited iron stand out well, as do the histiocytes in the alveolar spaces. Perl's ferrocyanide stain, X 250.

ous in the sinusoids, the lining cells of which were quite hyperplastic. Iron stains of the spleen, lymph nodes, liver, and lungs showed very large amounts of this metal in the parenchymal cells as well as in histiocytes. In the lungs iron was deposited upon fibers in the walls of alveoli and small vessels (fig. 3). These fibers were basophilic in routine hematoxylin and eosin stains and were negative for calcium. Iron stains of the bone marrow did not reveal positive results. All of the capillaries of the body contained young myeloid cells; and in some of the capillaries of the heart, lungs, and kidneys were atypical megakaryocytes. Throughout the loose connective tissue around some of the parenchymal organs there were groups of myeloid cells, as seen in leukemia.

In evaluating cases such as the one presented today, it is always best to have a complete laboratory workup. In this particular case it would have been quite desirable to have had a total blood volume test as well as more detailed information about the earlier peripheral blood and bone marrow findings. However, it seems that we do have enough clinical information to be fairly certain about the diagnosis of polycythemia vera. The leukocytosis and terminally the leukemoid reaction with a shift to the left are in keeping with the usual picture of polycythemia vera. Although the terminal peripheral blood differential does not allow an unequivocal diagnosis of leukemia, the histologic findings are certainly in keeping with this diagnosis. The myeloid cellular infiltration of the spleen, lymph nodes, liver, and especially the other parenchymal organs is the type seen in leukemia.

Very little has appeared in the literature on the pathology of polycythemia vera, as stated by Lawrence in a recent monograph.[3] Therefore, it is well to emphasize a few aspects of this particular feature. The gross pathology in most cases of polycythemia vera includes splenomegaly and hepatomegaly, with thromboses and infarctions a common feature due to high blood viscosity and perhaps to thrombocytosis as well. A small percentage of these patients have cirrhosis, and 10 to 40% have duodenal ulcer. A high percentage are found at autopsy to have massive hemorrhages or vascular thromboses and infarctions. In recent years many of these patients have died of acute granulocytic leukemia, which, according to Schwartz,[4] is consequent to an increased use of radioactive phosphorus. Occasional old thromboses with recanalization may be noted at autopsy. This was the finding at another recent autopsy at this hospital in which the peritoneal surfaces were covered by diffusely thickened fibrous adhesions with looping and kinking of many areas of the small bowel. In the wall of the superior mesenteric artery was an old, retracted, organized thrombus.

A very interesting problem in reference to the case we are presenting today is the positive iron stains in the spleen, lymph nodes, and liver, a uniform finding in polycythemia vera of long duration. In other cases examined iron was noted in the lungs only in those patients treated with phenylhydrazine. Hemolysis due to this drug is the

basis of the iron deposition. It is possible that the iron deposition noted in the parenchymal organs may have been a manifestation of a defect in iron metabolism; however, it is much more likely that it was a secondary manifestation of the disease and its treatment.

The splenomegaly, hepatomegaly, and pale bone marrow with only slightly enlarged lymph nodes are findings commonly seen in granulocytic leukemia. Although there is often a proliferation of many of the cells of the granulocytic series in granulocytic leukemia, the degree of megakaryocytic proliferation seen in this case is somewhat unusual. Similar cases with a very prominent megakaryocytic proliferation have been called megakaryocytic myelosis or leukemia. The massive infiltration of very young myeloid cells in all of the organs would leave little doubt about the diagnosis of granulocytic leukemia, and in view of the previous history we must conclude that this patient had polycythemia vera terminating in granulocytic leukemia.

This brings up the problem which Doctor Pisciotta has mentioned; namely, that of the myeloproliferative syndromes as postulated by Dr. Nathan Rosenthal and Dr. Dameshek.[1] On a histological basis this patient had granulocytic leukemia; polycythemia vera; and, to a minor degree, myelofibrosis; these are three of the five diseases listed under the myeloproliferative syndromes. Several authors have published reports on groups of autopsy cases which served as examples of these syndromes and have shown that they do have one common histologic feature; namely, the proliferation of myeloid cellular elements, the exact diagnosis depending upon which cell type proliferates at a greater rate. I have examined several other autopsied cases of polycythemia vera with varying features in the bone marrow. The myelofibrosis, not a prominent feature in our case, can be explained by a transformation of reticulum cells or similar precursors into fibroblasts. Similar findings were noted in some of these cases, as well as areas of hyperplasia and marked hypoplasia. Such a hypoplastic marrow was found in one patient who was extensively treated with radioactive phosphorus. A less variable histologic picture in the spleen and liver was present in other patients examined. In evaluating sections of the spleen in patients with secondary polycythemia, one does not see the myeloid metaplasia noted in these cases of polycythemia rubra vera.

In conclusion, we have presented the case of a woman who had polycythemia vera and in whom acute granulocytic leukemia eventually developed. Autopsy findings included gross features of granulocytic leukemia and histologic features seen in the myeloproliferative syndromes. Many of the pathologic features in the case warrant much further discussion.

REFERENCES

1. Dameshek, W.: Some observations in polycythemia vera, Bull. New England Med. Center 16:53–63 (June) 1954.
2. Valentine, W. N., and others: Biochemical studies in chronic myelocytic leukemia, polycythemia vera and other idiopathic myeloproliferative disorders, Blood 7:959–977 (Oct.) 1952.
3. Lawrence, J. H.: Polycythemia; Physiology, Diagnosis and Treatment, New York, Grune & Stratton, Inc., 1955, p. 12.
4. Schwartz, S. O., and Ehrlich, L.: Relationship of polycythemia vera to leukemia; critical review, Acta haemat. 4:129–147 (Sept.) 1950.

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Bowel Obstruction, Unusual Manifestation of Weber-Christian Disease

By MARVIN E. SATTLER, M. D., and A. I. GREENBERG, M. D.
Milwaukee

RELAPSING febrile nodular nonsuppurative panniculitis (Weber-Christian disease) is characterized by crops of subcutaneous nodules over the trunk and extremities. It also involves the adipose tissue of the heart, liver, spleen, pancreas, adrenal glands, and kidneys. The lesions have been found in the omentum, mesentery, peritracheal tissues, and submucosa of the gastrointestinal tract. This disease was first described by Victor Pfeifer[1] in 1892. Since then only about 60 cases have been reported in the literature.

Grossly, the characteristic nodules vary between 1 to 10 centimeters in diameter. They are a bluish-red or purplish-red and moderately firm; many have a cystic feel depending on the amount of fat necrosis.

Kennedy and Murphy[2] in 1949 suggested a relationship between Weber-Christian disease and dermatomyositis. Brudno[3] said his patient's disease was a collagen disorder. Weber-Christian disease also occurs with tuberculosis, syphilis, sporotrichosis, and leprosy. The actual cause is unknown.

The symptoms are recurrent, tender or nontender, subcutaneous nodules, occurring primarily on the abdomen, back, and thighs. Malaise, tachycardia, and extreme weakness appear when the temperature is elevated. There are generalized aches and pains; chills; joint pains; nausea; vomiting; headaches; and enlargement of the liver, spleen, and lymph nodes. Anemia, leucocytosis, and thrombocytopenia have been described although leucopenia has also been seen.

The autopsies of Spain, Foley, and Ungar[4, 5] showed lesions of the perivisceral adipose tissue and of the mesentery and omentum. Mostofi and Engleman[6] also found the visceral lesions, perivisceral nodules, and focal necrosis. It is this visceral involvement that has interested us because of the unusual complication of Weber-Christian disease that occurred in one of our patients. Extension of the disease to the perivisceral and intravisceral fat tissue creates an increased demand for phagocytes and a resultant hyperplasia of the involved organs. Another effect of perivisceral panniculitis is the thickening and fibrosis of organ capsules with loss of elasticity and tendency to constriction.

Individual attacks may resolve spontaneously, and recurrences are unpredictable. Various forms of therapy have given only temporary beneficial effect.

Case Report

D. K., a 29-year-old white female, was first admitted to the hospital on Feb. 11, 1955, with severe, unremitting, generalized abdominal pains, belching, and bloating, with some local tenderness in the gallbladder area. She had been having cramplike pains and vomiting for the past 36 hours. On admission the bowel sounds were absent, the abdomen was distended, the temperature was normal, and the white blood cell count was normal. Serum amylase was 70 mg. The rectal examination was negative. A palpable tender spleen and liver were found. A flat plate of the abdomen revealed some distended loops of small bowel; however, gas was present in the colon, and the x-ray diagnosis was adynamic ileus. A Miller-Abbott tube was passed, and the patient was placed on intravenous fluids and Achromycin.

The following day, the pain localized in the right upper quadrant and right lower quadrant. The patient appeared less toxic, and the distention decreased. She complained of a sore throat, her temperature was 102.8 F., and she began to pass tarry stools. After three days of treatment, she stopped vomiting, bowel sounds were present, and the Miller-Abbott tube was removed. She still complained of pain in the right upper quadrant and right lower quadrant of the abdomen. She continued to have several intermittent episodes of severe abdominal pain, associated with nausea and vomiting, in the next three weeks.

Fig. 1—Typical skin lesions of Weber–Christian disease involving the arm and face.

A gastrointestinal x-ray series done on March 1, 1955, revealed a normal gallbladder, a normal colon, and diffuse distention of the jejunum and duodenum. A gastroenterologist reported that the mucosal pattern indicated thickening of the folds and was suggestive of swelling.

On March 3, several erythematous, raised nodules appeared on the patient's abdomen and thighs (fig. 1). At this time she again became distended and began to vomit. She also complained of severe pain in the right lower quadrant of the abdomen. The surgical consultant at this time made a diagnosis of partial small bowel obstruction. A Miller-Abbott tube was passed, and the patient was prepared for surgery.

On March 6 she was taken to surgery, and many adhesive loops of ileum were found in the pelvis and the right upper quadrant of the abdomen. The bowel proximal to the adhesive obstruction was markedly dilated. The gallbladder, transverse colon, anl uterus were all involved in the adhesive obstruction. An end-to-end anastomosis was accomplished by resecting about 44 cm. of the terminal ileum. The pathological diagnosis of the bowel at this time was extensive fat necrosis in the mesentery and a necrotizing ulceration of the mucosa with inflammation of the entire bowel wall.

The patient made a good postoperative recovery until March 17, when multiple joint pains with swollen, tender knees and elbows appeared. Her temperature was 100 F., and the sedimentation rate 87 mm.; her electrocardiogram was normal except for sinus tachycardia. Her white blood cell count was 7,600; no eosinophils were present. The erythematous nodules again appeared over the abdomen, thighs, and face. This patient had the manifestations of Felty's syndrome at this time: anemia, leukopenia, polyarthritis, and splenomegaly. She was given sodium salicylate and cortisone and was discharged after 44 hospital days improved.

She was admitted to the hospital a short time later for biopsies of the skin nodules (fig. 2). A diagnosis of nonsuppurative nodular panniculitis of the abdomen was then made. After reviewing the bowel sections, the following observations were made by Dr. Norbert Enzer, pathologist at Mount Sinai Hospital, Milwaukee:

1. There is a necrotizing hemorrhagic ulceration of the mucosa with excessive mixed inflammatory cell infiltration of the entire wall, more extensive on the mucosal side.

2. Inflammation of the mesentery and lymph nodes, both acute as well as healing.
3. Vascular changes not present.
4. Infiltration of the fat is characterized by mixed cell reaction. Lymphocytes with liponecrosis and secondary granuloma type of infiltration reaction (fig. 3).

The pathologist felt that we were dealing with a diffuse inflammatory process involving the fat tissue. In light of the lesions found in the subcutaneous tissue, he suggested that this was a component of a Weber-Christian syndrome.

In September, 1955, considerable abdominal pain requiring hospital care for three days developed. A month later a transverse colostomy was done at University Hospitals, Madison, because of a pelvic abscess due to a fistula from the sigmoid colon.

The patient was again seen by us in January, 1956, complaining of weakness, weight loss, and diarrhea from the colostomy. Her weight had dropped from 169 to 94 pounds; the skin lesions were in the stage of remission and exhibited flat, atrophic, scarred areas. Barium enema x-rays were normal, and laboratory work was normal except for a white blood cell count which ranged between 2,000 and 4,000.

Thereafter, with massive doses of vitamins B and C she gradually improved and gained weight. She was discharged on January 29, somewhat improved, after 26 hospital days.

This patient will be followed for several months and then rechecked by barium enema x-rays prior to closing the transverse colostomy.

At the present time, she is fairly comfortable and has gained weight. Her skin lesions are at a stage of remission; however, the ultimate prognosis is very guarded.

(M. E. S.) 161 West Wisconsin Avenue.

Fig. 2—Dermis, subcutaneous tissue, showing atrophy of the epithelium and granulomatous involvement of fat with necrosis (X 50).

Fig. 3—Wall of small bowel showing fat necrosis with mixed inflammatory cell reaction (X 200).

REFERENCES

1. Pfeifer, V.: Ueber einen Fall von herdweiser Atrophie des subcutanen Fettgewebes, Deutsches Arch. klin. Med. 50:438–449, 1892.
2. Kennedy, R. J., and Murphy, L. R.: Weber–Christian disease. Am. J. Med. 6:672–680 (May) 1949.
3. Brudno, J. C.: Chronic relapsing febrile nodular nonsuppurative panniculitis (Weber–Christian disease); relation to rheumatic fever and allied diseases, New England J. Med. 243:513–517 (Oct. 5) 1950.
4. Ungar, H.: Relapsing febrile nodular inflammation of adipose tissue (Weber–Christian syndrome); report of case with autopsy, J. Path. & Bact. 58:175–185 (April) 1946.
5. Spain, D. M., and Foley, J. M.: Nonsuppurative nodular panniculitis (Weber–Christian's disease), Am. J. Path. 20:783–787 (July) 1944.
6. Mostofi, F. K., and Engleman, E.: Fatal relapsing febrile nonsuppurative panniculitis, Arch. Path. 43:417–426 (April) 1947.
7. Weber, F. P.: Relapsing non-suppurative nodular panniculitis, showing phagocytosis of subcutaneous fat-cells by macrophages, Brit. J. Dermat. 37:301–311 (July) 1925.
8. Beerman, H.: Weber–Christian syndrome, Am. J. M. Sc. 225:446–462 (April) 1953.
9. Miller, J. L., and Kritzler, R. A.: Nodular nonsuppurative panniculitis, Arch. Dermat. & Syph. 47:82–96 (Jan.) 1943.
10. Charache, H.: Relapsing febrile nodular nonsuppurative panniculitis (Weber–Christian syndrome), New York J. Med. 52:1133–1136 (May 1) 1952.
11. Eisaman, J. L., and Schneider, L. A.: Nodular nonsuppurative panniculitis (Weber–Christian disease), J.A.M.A. 146:1417–1418 (Aug. 11) 1951.
12. Steinberg, B.: Systemic nodular panniculitis, Am. J. Path. 29:1059–1081 (Nov.–Dec.) 1953.
13. Friedman, N. B.: Fatal panniculitis, Arch. Path. 39:42–46 (Jan.) 1945.
14. Bendel, W. L., Jr.: Relapsing febrile nodular panniculitis (Weber–Christian disease); review of literature and report of case, Arch. Dermat. & Syph. 60:570–596 (Oct.) 1949.

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The following guides and manuals are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin:

1. **Interprofessional Code**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
3. **Code of Necropsy Procedure**—A guide to physicians, hospitals, and funeral directors in the performance of necropsies.
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"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

Dr. Alfred E. Belitz, who did much to preserve and mark historic sites in his section of Wisconsin, was described as one of Pepin's "most honored and respected citizens" after his death at 87 three years ago. Active in civic, community, and area activities of all kinds, the physician was cited on "Doctor Belitz Day" in 1950 for 32 years of service in the community.

To help perpetrate his memory, Mrs. Belitz gave his records, account books, case histories, and other material to the State Historical Society of Wisconsin to add to its collection of medical artifacts.

Doctor Belitz practiced in Utah, Washington, and California, and in Milwaukee, Cochrane, and Waumandee, Wisconsin. He was a member of the State Medical Society's "50 Year Club."

* * *

Mrs. Adellon D. Andrus of Ashland donated an amputation kit, a carton of instruments, and diathermy apparatus. Her husband, who died in 1955, was a pioneer practitioner in northern Wisconsin, beginning 44 years ago.

He served as assistant superintendent of the Wisconsin State Tuberculosis Sanatorium at Wales before coming to Ashland, and in the U. S. Army Medical Corps in World War I. For many years he was medical officer in the U. S. Indian Service and acting Ashland County physician. He was a general practitioner, with special residency work in internal medicine and pulmonary diseases.

* * *

Recently Dr. Bertha E. Reynolds, Avoca, gave the Section on Medical History a doctor's chair she used before her retirement. The heavy chair flattens out into an examining table. It is a real relic. It had been used for many years before Doctor Reynolds had it by Dr. William Reese, Dodgeville, who died in 1949 at the age of 91.

Doctor Reynolds also presented the Section her sidesaddle, which she had put to good use on her frequent trips to patients in Iowa and Richland counties. Also forwarded to the State Medical Society was a set of surgical instruments.

LUIDA SANDERS of the State Board of Health staff and Carl Guell, assistant director of the State Aeronautics Commission, look over the chair donated by Dr. Reynolds. Miss Sanders is holding the obstetrical grip donated by Mrs. Lundmark.—(Cliff Hutchinson Photo)

After Doctor Reese's death, the *Dodgeville Chronicle* commented editorially:

"In its more than 100 years of history, no Dodgeville citizen has been more valuable or unselfish than this doctor. He truly has been Iowa County's 'grand old man of medicine.' "

* * *

An obstetrical grip that traveled many miles by sleigh, on foot, and horse and buggy with the late Dr. Lambert M. Lundmark of Ladysmith was donated to the Section this fall by Mrs. Lundmark.

The grip has a built-in container for a copper sterilizer with cover. It was designed by the physician principally for the performing of deliveries in homes.

Mrs. Lundmark also sent the Section Dr. Lundmark's diploma from the University of Minnesota Medical School, dated 1904; his Wisconsin Board of Medical Examiners certificate, dated the same year; and various other membership certificates dated during the past half century.

. . . . THE PRESIDENT'S PAGE . . . .

The Personal Touch

DURING the past few months I have had the opportunity to attend meetings of physicians in many parts of the state. During a break in a meeting at Lancaster, Doctor Howell of Fennimore suggested that I accompany him to see his patients in the Lancaster Memorial Hospital. I was amazed. Here in a small community was a well-equipped hospital with fine x-ray facilities, operating, delivery, and patient rooms, all spotlessly clean and restful. This hospital and its staff is rendering excellent service to the people of Lancaster. I was told that Boscobel and Platteville have similar new hospitals.

I began to think of the many fine new hospitals in Wisconsin, including the one here in Osceola. Public-spirited citizens, with some federal help at times, and with the cooperation of the State Board of Health and Mr. Vincent Otis, Director of the Board's Division of Hospital and Related Services, have certainly improved the medical care in rural communities. And once the facilities are there, no one would give them up.

I thought, too, of the many advances in medicine—things that have made people live longer and more happily such as penicillin, insulin, Salk vaccine for polio, delicate heart surgery, and many other technical procedures.

Then I began to wonder further. With all this fine progress in medical care, have we kept the "art of practice" in tune with the times? It is not alone because of our own efforts that we are in an honored profession. Physicians are revered in part because the older family doctors and those who have gone before us, whether they knew it or not, had good patient relations. They, like present practitioners, were honest in their attempts to help patients, but they had one unusual trait—they had to make up in personal intent what they lacked in knowledge.

We have a great heritage. The members of our profession are highly honorable men. Let's not allow a few physicians to make it appear that doctors are selfish, unsympathetic, and interested only in their personal gain. Each of us, by adding the personal touch to his scientific excellence, can help keep the medical profession in its high place of public esteem.

L. O. Sinenstad M.D.

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Thoughts on Rural Health

For well over 100 years the State Medical Society of Wisconsin has labored to improve the health of the people of our state. Working hand in hand with the State Board of Health, the University of Wisconsin, and many other groups, our Society has established a creditable record. Looking back over the years, it seems to me that doctors as a rule have not felt their individual responsibility in disease and accident prevention previous to the last two or three decades. Interest in rural health problems has been of still later concern.

Why Bother

There are many reasons for a sustained effort in rural health betterment, among which can be included:

1. Our lives depend upon food and fiber
2. So much of Wisconsin is rural
3. Home and farm life approaches the ideal environment for raising children.

Education

Education for the preservation of life and health must be a continuing process. New crops of children have to be taught each year how to care for their bodies and how to ward off accidents. Experience may be the best teacher, but it can be a costly one. As far as accidents are concerned, the best thing for parents to do is to teach children to be "accident conscious." When a child or an adult is classified as "accident prone," it may be a reflection of his lack of education in the home and in the school. All agencies and individuals dealing with our youth share the responsibility. Certainly not the least are the physicians themselves as family advisors.

Times Change

These are changing times. Vaccine against polio; routine chest x-rays; cell stains for early cancer diagnosis; and safety devices on farm machinery, cars, and trucks are the comparatively recent advancements to preserve life and limb. But there must be a zeal on the part of doctor and public alike for their full utilization.

What of the Future

I cannot subscribe to the phrase in a current popular song, "What will be, will be." Instead, what the future holds for us depends largely upon what

we do, not only for ourselves but for others. We have come a long way in health matters when one compares past and present treatment, living conditions, and vital statistics; but we must go forward to an even better life in the home, factory, and farm. County medical societies in rural Wisconsin can help shape the future by working as a team or individually in one or more of the following projects:

1. Conducting health surveys on diabetes, cancer detection, health hazards, and tuberculosis.
2. Fighting the cultists and other uninformed groups to secure clean, fluoridated water.
3. Struggling to protect every child against polio and against every preventable disease.
4. Conducting surveys on farm and home accidents.
5. Planning county–community Health Days.
6. Organizing county health councils.

In Conclusion

I am mindful of all the different activities available to county societies in rural areas which would provide more and better medical service. Our society is pledged to join a program for early diagnosis of cancer through the use of cytological procedures which is being directed by Dr. W. D. Stovall of the State Laboratory of Hygiene. What will you do? Certainly Dr. "Davy" Crockett, chairman of the Council on Rural Health of the American Medical Association, as well as our own Council on Medical Service, will be greatly interested in any action taken to improve rural health and prevent accidents.

—R. L. MacCornack, Sr., M. D.

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Tuesday, January 15—Madison ..... St. Mary's Hospital
Wednesday, January 16—Oshkosh ..... Mercy Hospital
Thursday, January 17—Sheboygan ..... St. Nicholas Hospital

Moderator: **Robert C. Parkin, M. D.**, Madison

Faculty and Subjects to be Covered:

John Hirschboeck, M. D., Milwaukee: *Hematologic Problems in Children*
Howard Lee, M. D., Milwaukee: *Bronchial Asthma, and What Can We Do About It*
Ralph Reis, M. D., Chicago: *Indications and Avenue of Approach for Hysterectomy*
James Stack, M. D., Chicago: *Low Back Pain*

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twentieth annual meeting of The New Orleans Graduate Medical Assembly will be held March 11, 12, 13 and 14, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, scientific exhibits, medical motion pictures, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1957 meeting in New Orleans. On Saturday, March 16, a party composed of doctors and their families will leave from New York for the Mediterranean and Europe via plane. The itinerary includes France, Greece, Turkey, Egypt, Jerusalem, Lebanon, Syria, and Italy. Arrangements have been made for medical programs in the places visited. The official tour terminates in Rome on Friday, April 12, but arrangements may be made for independent travel to any points in Europe desired, with return to the United States by air or steamer.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Society Proceedings

Green

The monthly meeting of the Green County Medical Society was held September 25 at the Monroe Country Club. About thirty members of the society enjoyed an afternoon of golf, followed by dinner.

Mr. R. P. Regez was the guest speaker. He discussed what social security would mean to the medical profession.

Jefferson

Twenty-four members of the Jefferson County Medical Society met September 20 at the Great Oaks Tea Room in Jefferson. *Dr. Forde A. McIver* of the University Hospitals in Madison was the guest speaker. He chose as his topic "The Chemical Treatment of Cancer."

During the business session which followed the address, members gave approval to conducting public health polio vaccine clinics on a county-wide basis.

Kenosha

The Kenosha County Medical Society met October 4 at the Elks Club in Kenosha. Dr. Luis Amador, assistant professor of neural surgery at the University of Illinois College of Medicine, addressed the group on "Interesting Neurosurgical Cases." Forty-five members were present at the meeting.

During the business session, a committee was appointed to formulate a standardized insurance form.

Outagamie

Forty members of the Outagamie County Medical Society met September 20 at the Elks Club in Appleton.

During the business session of the meeting the following measures were approved:

1. Adoption of the newly revised county fee schedule
2. Contribution to Society of Medical Research.

Guest speakers at the meeting were *Dr. R. L. Rice*, professor of clinical medicine at Marquette University, and *Dr. P. S. Pierson*, clinical instructor in pediatrics at Marquette. They spoke on "Rheumatic Fever Team." Remarks were made by Miss Lucille Rabe, program chairman of the Wisconsin Heart Association. General aspects of clinical findings and treatment of rheumatic fever were discussed.

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Pierce–St. Croix

The regular monthly meeting of the Pierce–St. Croix County Medical Society was held on October 16 at The Steak House in Somerset. *Dr. J. P. Healy,* New Richmond, was the host.

Sauk

A dinner meeting of the Sauk County Medical Society was held October 9 at the Warren Hotel in Baraboo. William F. Fries, district federal social security representative, spoke to the group about social security.

Fifteen members of the society met September 11 at the Warren Hotel for their annual public health meeting. Guest speaker was A. B. Abramovitz, director of the Child Guidance Division of the State Board of Health, Madison. His talk was about child guidance clinics.

During the business session which followed the address, Elizabeth Terry, R. N., Sauk County public health nurse, gave her report and recommendations to the society, and these recommendations were accepted.

Trempealeau–Jackson–Buffalo

The regular monthly meeting of the Trempealeau-Jackson–Buffalo County Medical Society was held September 25 at the Hotel Freeman, Black River Falls. Three physicians from the Marshfield Clinic were the guest speakers.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met September 8 and 9 at Eagle Waters Resort in Eagle River. The program included talks by Drs. George Guibor of Chicago, associate professor of ophthalmology at Northwestern University, and W. B. Larkin of Marshfield, and also a round-table discussion.

Doctor Guibor spoke on "Practical Applications of Neuro-Ophthalmology" and "Nonsurgical Treatment of Nonparalytic Strabismus." Doctor Larkin presented a talk entitled "A Review of Surgical Procedures to Restore Hearing."

Wisconsin Society of Internal Medicine

The second annual fall scientific meeting of the Wisconsin Society of Internal Medicine was held September 15 in Madison at University Hospitals. About 120 physicians attended.

Election of officers was held, and *Dr. Karl H. Doege,* Marshfield, was named the organization's second president, succeeding *Dr. Maurice Hardgrove,* Milwaukee, who became president last year when the society was formed.

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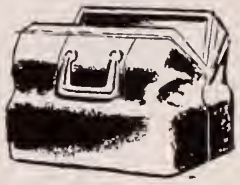

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Dr. Robin N. Allin, Madison, became vice-president, and *Dr. Paul G. LaBissoniere*, Milwaukee, was elected secretary–treasurer.

Directors named by the society were: *Dr. Maurice Hardgrove; Dr. R. L. Gilbert*, La Crosse; *Dr. W. K. Simmons*, Rhinelander; and *Dr. H. M. Snodgrass*, Janesville.

Officers were installed at a banquet held in the evening at the Madison Club.

Tenth Councilor District

The Tenth Councilor District held its fifty-sixth annual meeting Wednesday, October 10, at the Hotel Eau Claire, Eau Claire.

Following registration, *Dr. Ovid Meyer*, professor of medicine at the University of Wisconsin, spoke on "Newer Drugs, Uses and Abuse." *Dr. N. J. Helland*, urologist at the Marshfield Clinic, presented a talk on "Treatment of Urinary Tract Infections."

"Endocrine Problems in Children" was the subject chosen by *Dr. E. S. Gordon*, professor of medicine at the University of Wisconsin. Guest speaker, Dr. Lyle French, from the Division of Neurosurgery at the University of Minnesota, discussed "Treatment of Closed Head Injuries."

An after-dinner address was given by Mr. Glenn V. Rork, past president of Northern States Power Company and lay member of the National Committee on Schizophrenia.

Milwaukee Neuro-Psychiatric Society

The regular monthly meeting of the Milwaukee Neuro-Psychiatric Society was held at the University Club, Milwaukee, on October 17.

Following a business meeting, social hour, and dinner, the group had a program honoring *Dr. Michael Kasak*, recently retired medical director of the Milwaukee County Hospital for Mental Diseases. Addresses paying tribute to him were given by *Drs. William H. Studley, H. H. Reese*, and *S. K. Pollack*.

News Items and Personals

Dr. Rogers Addresses Auxiliary Meeting

Dr. R. J. Rogers, Oconto pathologist, was the guest speaker at the opening meeting of the Woman's Auxiliary to the Community Memorial Hospital in Oconto on September 10.

He outlined the work of a pathologist, stating that by examination of tissues removed from the body many patients are saved from unnecessary surgery. Doctor Rogers pointed out that a pathologist is sometimes termed "a doctor's doctor."

Dr. Pawsat Speaker at Youth Meeting

Dr. E. H. Pawsat, chairman of the Division on School Health of the State Medical Society and practicing pediatrician in Fond du Lac, addressed a recent district Conference on Children and Youth. The meeting was held October 6 at the Berlin High School.

Dr. Henke Addresses Shawano Rotarians

Dr. F. W. Henke, Shawano, addressed members of the Shawano Rotary Club on Monday, September 17.

He spoke on drowning accidents and gave special emphasis to artificial respiration. He recommended that all persons know how to administer artificial respiration and suggested that, in case of apparent drowning, respiration be administered immediately and the sheriff or city police called promptly so that the resuscitator might be put into use to assist the victim in breathing.

Dr. Brousseau Heads Sclerosis Board

Appointment of *Dr. E. R. Brousseau*, neuropsychiatrist now practicing in Eau Claire, as chairman of the medical advisory board of the Chippewa Valley Chapter of the National Multiple Sclerosis Society was announced September 28.

Doctor Brousseau is a graduate of the University of Minnesota and the University of Nebraska College of Medicine. He is a member of the American Psychiatric Association.

Other members of the advisory board are: *Dr. R. M. Lotz*, Eau Claire; *Dr. A. W. Hilker*, Eau Claire; and *Dr. John Toussaint*, Chippewa Falls.

New Clinic Being Built in Ashland

Drs. H. H. Larson and *J. M. Jauquet* will staff a new clinic now being erected in Ashland. The clinic will be completed some time in December and will have complete diagnostic facilities, including electrocardiograph, x-ray, diathermy, and laboratory facilities.

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Chicago Medical Society

March 5, 6, 7 and 8, 1957

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The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

THIRD AND TWELFTH DISTRICTS NEWS

Dr. Schwade Has New Associate

Dr. Edward D. Schwade, Milwaukee, recently announced the association with him in the private practice of neuropsychiatry of Dr. Jean P. Davis.

Doctor Davis received her medical degree from Yale University in 1943. In 1944–45 she served as assistant resident in pediatrics at Strong Memorial Hospital, Rochester, New York, and from 1945–1946 as resident at the Convalescent Home for Children, Wellesley, Massachusetts. She was a research fellow in pediatrics at Harvard University for three years—from 1945 to 1948. Then she was on the staff at the University of Utah until 1953, when she took postgraduate training at the Institute of Neurology, Queen Square, London. Prior to coming to Milwaukee, Doctor Davis was assistant professor of neurology, Columbia University, and assistant attending neurologist, Presbyterian Hospital. She was certified by the American Board of Pediatrics in 1950.

Doctor Collentine Discontinues Practice

Dr. George E. Collentine, Milwaukee, has discontinued his medical practice and has returned to college. He left Milwaukee the week of September 16 to enroll as a liberal arts student at St. John's University at Collegeville, Minnesota.

Madison Physicians Participate in Meeting at Wausau

Madison was represented by specialists in medicine, law, and blood at the joint two-day session of the Wisconsin Society of Pathologists, Minnesota Clinical Pathologists, and Wisconsin Association of Blood Banks held at Wausau on September 14 and 15.

Dr. Chester M. Kurtz, cardiologist, and attorney Oscar Toebaas were participants in a panel discussion on the legal aspects of trauma and disease, particularly in coronary cases, at the pathology session Friday, September 14.

Dr. Etheldred L. Schafer of the Jackson Clinic, Madison, and L. J. Petersen, administrator of the Badger Regional Blood Center of the American Red Cross, program chairman and vice-president respectively of the Wisconsin Association of Blood Banks, presided at the morning and afternoon sessions.

Doctor Foseid Fellow of ICS

Dr. Oscar F. Foseid, Madison, was made a certified fellow of the International College of Surgeons at its meeting held on September 9–14. Doctor Foseid is on the staff of the Jackson Clinic in Madison.

Dr. Ewell Named ICS Regent for Wisconsin

Dr. George H. Ewell, of the Jackson Clinic, Madison, has been appointed International College of Surgeons regent for Wisconsin by the new president of ICS, Dr. Curtice Rosser, Dallas. The appointment was made at the recent meeting of the College held in Chicago.

Correction

In our October issue, page 1131, we incorrectly stated that *Dr. L. R. Prouty* is associated with the Dean Clinic, Madison. He is associated with the Quisling Clinic.

SOCIETY RECORDS

New Members

Charles E. Theisen, 928½ Milwaukee Avenue, South Milwaukee.

O. E. Miller, 425 East Wisconsin Avenue, Milwaukee.

R. C. Zastrow, VA Hospital, Wood.

N. R. Thomson, 1800 East Capitol Drive, Milwaukee.

R. K. Voet, 2320 North Lake Drive, Milwaukee.

John F. Brown, 1020 Kabel Avenue, Rhinelander.

Ihor A. Galarnyk, Plain.

H. A. L. Hartmann,* 31 University House C, Madison.

J. H. Turgeson, 209 South Charter Street, Madison.

W. C. Bogle, 2020 University Avenue, Madison.

Changes of Address

D. E. Hoff, Eau Claire, to 1300 University Avenue, Madison.

J. F. Coyne, Jr., Fond du Lac, to 341 Ruger Heights Road, Janesville.

J. O. Hadley, Watertown, to 559 North 93rd Street, Milwaukee.

Leo Harkavy, Wood, to 1305 Franklin Hospital, Oakland, California.

G. J. Bordenave, San Francisco, California, to 401 Campbell Street, Geneva, Illinois.

Isabel V. Estrada, Milwaukee, to 1460 Ponce de Leon Avenue, Santurce, Puerto Rico.

H. L. Bartsch, Madison, to 512 Sherland Building, South Bend, Indiana.

H. H. Meusel, Oshoksh, to 320 Rose Avenue, Fond du Lac.

C. J. Wheeler, Madison, to 420 Cherry Street, Evansville, Indiana.

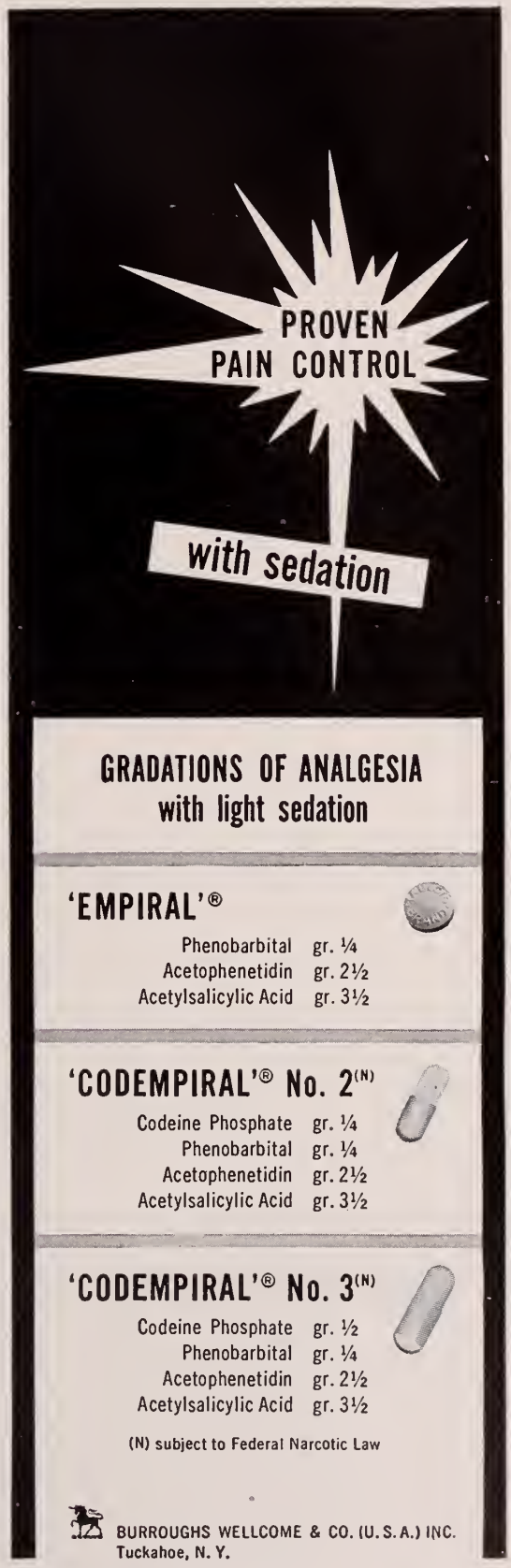
F. J. Glassy, Milwaukee, to St. Joseph's Hospital, Marshfield.

J. A. Marks,** Houston, Texas, to 1545 West 23rd Park, Topeka, Kansas.

E. L. Bolton, Appleton, to Yacht Basin Apartments G25, Clearwater Beach, Florida.

J. S. Horning, Milwaukee, to 3530 West Congress Parkway, Chicago, Illinois.

* Reinstated Member.
** Military Service.



W. E. Mateicka, Cheyenne, Wyoming, to Route 1, Box 34C, Sussex.

C. L. Rumph, South Milwaukee, to 1370 136th Street, N. E., North Miami, Florida.

J. S. Stehlin, Houston, Texas, to 605 Commonwealth Avenue, Boston, Massachusetts.

G. B. Theil, Milwaukee, to 401 North Oneida Street, Appleton.

T. E. Kilkenny, Delavan, to 512 Garfield Avenue, Eau Claire.

R. L. Smith, Milwaukee, to Marshfield Clinic, Marshfield.

E. F. Kuglitsch, Black River Falls, to 5600 Euston Street, Greendale.

Harold N. Lubing,** Great Lakes, Illinois, to 110 East Main Street, Madison.

Stephen Cahana, Los Angeles, California, to 8108 North Santa Monica Boulevard, Milwaukee.

T. B. Puls, Milwaukee, to 11006 West Godsell Avenue, Hales Corners.

M. D. Davis, Brookline, Massachusetts, to 224 West Washington Avenue, Madison.

** Military Service.

OBITUARIES

Dr. Frank T. McHugh died September 5 at the age of 75 years at a Chippewa Falls hospital following a short illness.

Doctor McHugh was born in 1881 at Chippewa Falls. He was graduated from Loyola University Medical School in 1911, and interned at Cook County Hospital, Chicago. He had practiced medicine in Chippewa Falls from 1915 until the time of his retirement in 1945.

He was a member of the Chippewa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving Doctor McHugh are his wife, Ida; four sons, Franklin T., Baltimore, Maryland; William J., Albuquerque, New Mexico; John D., Evanston, Illinois; and Daniel F., Forest City, North Carolina; and three daughters, Margaret H., Ann Arbor, Michigan; Mrs. Charles Burbank, Brookline, Massachusetts; and Mrs. Neal J. O'Byrne, Denver, Colorado.

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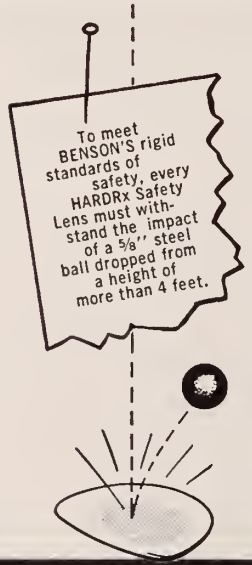

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THE MEDICAL FORUM

Physicians! Enroll Now in Your Blue Shield–Blue Cross Plan

MADISON—NOW IS THE TIME, Doctor, to buy or to make changes if need be, in Blue Shield–Blue Cross coverage for you and your family.

Wisconsin physicians are reminded that the annual enrollment for their own health care coverage is scheduled for this month.

Coverage becomes effective December 1.

So, here's your opportunity—right now—to do the following things:

1. Buy Blue Shield and/or Blue Cross for you and your family.
2. *Add Blue Shield to an existing Blue Cross policy.*
3. Change coverage, and here's what you can change: a) Blue Shield from "B" to "A" schedule– b) Blue Cross from Comprehensive to Comprehensive Co-insurance, or vice versa.
4. *Change from a single contract to a family contract, if this is needed.*
5. Change from a non-group or conversion contract to the State Medical Society Group.

The special plan was devised two years ago for State Medical Society members engaged in active practice. It enables the members, other than those in Milwaukee County, to purchase Blue Shield and/or Blue Cross without a health questionnaire. Milwaukee County physicians utilize a plan arranged with Surgical Care.

NOTE:

It is advisable for physicians now covered by Blue Shield—Blue Cross through regular groups, such as clinics, hospitals and the like, to continue their existing coverage rather than transfer to the S.M.S. group.

Physicians who fail to enroll within the next month — new members excepted — cannot enroll until next fall.

There's a choice of Comprehensive Blue Cross protection:

The 70-day Comprehensive contract OR *the new Co-insurance program under which the physician assumes 25 per cent of the first $400 of hospital charges normally covered by the contract.*

The Comprehensive contract provides for the payment of the full cost of a semi-private room, $7.50 allowance toward the cost of a private room, and 100 per cent of most other hospital charges.

Blue Shield offers either the "A" or "B" schedule with benefits for surgery, maternity and in-hospital medical care (70 days). In addition, payments are made for anesthesia and x-ray when performed and billed by a physician and associated with surgery or maternity.

FOR INFORMATION PLEASE COMPLETE AND RETURN THE CARD IN THIS ISSUE OF THE JOURNAL.

DR. STOVALL RENAMED TO BLOOD BANK ASSN.

MADISON — Dr. William D. Stovall, Madison, director of the State Laboratory of Hygiene and a past president of the State Medical Society, has been renamed the Society's representative to the Wisconsin Association of Blood Banks.

The appointment was made by Dr. L. O. Simenstad, Osceola, Society president.

Note on Alcoholism

On Page 1201 of this month's Wisconsin Medical Journal will be found a coupon which will bring a subscription to "Keystone," a professional digest publication designed to inform readers on problems, trends and news concerning alcoholism. The publication will be mailed without cost to any Wisconsin physicians who request it.

Physician Enrollment In Blue Shield Shows Increase

MADISON — Why do you buy Blue Shield–Blue Cross coverage for your family, Doctor?

The increase in physician enrollment, especially in Blue Shield, has been discussed widely.

The majority recognize that growing specialization in medicine often compels a doctor to seek attention for himself or his family from a specialist whose services he may not be able to reciprocate and who won't accept payment from him.

Blue Shield relieves his hesitancy to seek such help, since his fellow physician receives the regular W.P.S. allowance toward the cost of his medical care and thus is spared the embarrassment of an unpaid obligation.

The tradition of physicians caring "for their own" still has not been replaced in day to day medical services for members of physicians' families, but changing methods of practice and the ability to go long distances for special care has encouraged the use of Blue Shield and Blue Cross.

FOLLOWING A TREND

Some physicians wish to preserve the tradition by which they and their families receive care from fellow doctors on a courtesy basis, but their number is decreasing.

The fact that their doctors are themselves Blue Shield–Blue Cross members is a strong endorsement to patients that the Plans offer the best protection against hospital and medical costs.

A.M.E.F. REPORTS AUXILIARY GIFTS

CHICAGO—The American Medical Education Foundation reported the following recent contributions:

From the Woman's Auxiliary to the State Medical Society of Wisconsin, $451; the Woman's Auxiliary to the Medical Society of Milwaukee County, $1,131 and from the Woman's Auxiliary to Dane County, $250.

QUACKERY FIGHT SPURRED BY CANCER COMMITTEE

INFORMATION TO BE SOUGHT FROM PHYSICIANS IN WISCONSIN

MADISON—Efforts to uncover quackery in Wisconsin are being undertaken by the State Medical Society's Committee on Cancer.

Member physicians will be asked in the near future to submit information concerning their knowledge and experiences of patients with the so-called Koch treatment, Hoxsey claims and other alleged cancer cures.

Information thus gained will be used to expose unscientific cures and to educate the general public on the fraudulent operations of the cultists.

The Committee, meeting here recently, recommended that the lay organization of the Wisconsin Division, American Cancer Society, support the study by reporting any method of quack treatment and sufficient data to back up the reports.

Committee members present at the meeting included Drs. R. C. Cantwell, Shawano, chairman; P. B. Blanchard, Cedarburg; R. J. Schacht, Racine; R. P. Welbourne, Watertown; A. R. Curreri, Madison and Ralph C. Frank of Eau Claire.

PRESIDENT PRESENT

Also present were Drs. L. O. Simenstad, Osceola, president of the State Medical Society; H. E. Kasten, Beloit, president-elect; William D. Stovall, Robert J. Samp, A. L. Van Duser and F. A. McIver of Madison.

Also urged were articles and editorials in the Wisconsin Medical Journal and speakers on the subject of cancer quackery at county medical society meetings.

Dr. Stovall described the progress of the federal program utilizing the Papanicolaou smear test for cancer in 10 Wisconsin counties. He said 50 to 100 smears were being received daily, but an effort was being made to build this up to 200.

Dr. Stovall, who was praised highly by Committee members for his progress on the Papanicolaou smear test, said that all but one of the counties — Dane — is almost exclusively rural. The tests are also being conducted with the cooperation of physicians and county medical societies in Buffalo, Green Lake, Jackson, Oneida, Polk, Sauk, Trempealeau, Vilas and Waushara counties.

It was brought out that cooperation of the physicians and the local societies is a vital part of the program, a necessary ingredient to making the project a success. Physicians were asked again by the Committee to fulfill all requests for cooperation.

Financed by the U. S. Public Health Service, the smear tests are for cancer of the cervix and uterus, described as the most prevalent types among women. The procedure is for a local doctor to ask his women patients, whether he sees them for a cold or because they suspect cancer, to permit him to take tests. These are checked in Madison at the State Laboratory of Hygiene, of which Dr. Stovall is director.

Reports are returned to the physician. If the presence of cancer is indicated, prompt treatment can begin.

The program was started last January. It is expected to continue from three to five years. He said the success of the program also depends on cooperation of the women, who will be its beneficiaries.

The Committee urged use of speakers at post-graduate clinics and county medical society meetings on the emotional aspects of malignancy, the physician's responsibility for consideration of the patient's feelings in terminal cases.

A discussion followed on the House of Delegates resolution asking for expansion and coordination of post-graduate medical education programs in Wisconsin. A proposal of the Society's Council on Scientific Work, the resolution was designed to integrate such education. It also was introduced to avoid duplication of dates, to present a more unified program and to make physicians aware that these programs are part of the over-all medical education program supported by S.M.S.

Support for the resolution was voted by the Committee, and the Medical and Scientific Committee of the Wisconsin Division, American Cancer Society, later took a similar stand.

OK PSYCHIATRY TRAINING PLAN

MADISON—A joint psychiatric training plan has been worked out by the University of Wisconsin Medical School and the State Department of Public Welfare.

In return for $9,100 in payments for three years of residency at Wisconsin General Hospital, Madison, the trainees must agree to work two years in a state welfare institution. The program can handle 21 trainees each year.

The State Medical Society's Division on Nervous and Mental Diseases has actively sought such a program for a number of years.

Dr. Leslie A. Osborn, Department mental hygiene director, said the action was taken to alleviate the shortage of psychiatrists. Currently, the Department has 16 to 18 positions unfilled. It also has a number of positions filled by physicians with little or no psychiatric training.

"FORWARD STEP"

Dr. William D. Stovall, Madison, director of the State Laboratory of Hygiene, and chairman of the State Welfare Board, called the joint program *"a very forward step"* which would benefit the mental hygiene program, the U.W. Medical School and the public.

Dr. John Z. Bowers, dean of the School, endorsed the plan.

The Department already has a state-subsidized fellowship program set up for neurology and psychiatry. This is a five-year U.W. training program for persons with M.D. degrees.

The Mendota State Hospital, near Madison, also has a residency program in psychiatry, under state civil service.

NAME DR. HOWELL TO CANCER GROUP

MADISON — Dr. Ernest C. Howell, Fennimore, has been appointed by the State Medical Society to its Committee on Cancer.

Dr. Howell was named to succeed Dr. John W. Conklin, of Platteville, who recently moved to Louisiana. The term will end in 1959.

A general practitioner, Dr. Howell was graduated from the Marquette University School of Medicine. He is a member of the Grant County Medical Society, the State Medical Society and the American Medical Association.

By virtue of the appointment, Dr. Howell became a member of the Medical and Scientific Committee of the Wisconsin Division and Board of Directors of the American Cancer Society.

IN AGREEMENT—are Dr. Forde A. McIver (left), assistant director of the University of Wisconsin Medical School Tumor Clinic, and Dr. R. C. Cantwell, Shawano, Chairman of the S. M. S. Committee on Cancer. Dr. McIver reported to the Committee Sept. 30 on a proposal calling for a tumor registry at the Clinic.

WPS MAKES REPORT ON CLAIMS PAID

MADISON — Wisconsin Physicians Service paid out $2,283,296 for claims during the first seven months of 1956.

The largest portion, $1,200,428, went for surgery-in hospital claims.

In July, WPS had 73,895 contracts under the "B" schedule; 55,840 under the "A" and 3,942 under "special service" coverage. The total, 132,630, represented a gain of 4,911 since January 1.

Twenty-two firms were added during July, aggregating 707 contracts.

STATE LABORATORY OF HYGIENE, MADISON—These ladies are cooperating with physicians in 10 counties in the program using the Papanicolaou test for early detection of cancer in women. Shown checking slide smears are (left to right) Mrs. F. E. Staab, Mrs. Ed Stephan, Miss Alice Fay and Mrs. Ted Clarke, training director, all of Madison.—(U. W. Photo)

AMA COMMITTEE ASKED TO DRAFT LAW ON LABELING

CHICAO — The American Medical Association's Board of Trustees has authorized the A.M.A. Committee on Toxicology to draft a recommended "model" law on labeling of many possibly harmful chemicals not now regulated.

Products involved include auto care and repair materials, paints and paint removers, putty, soldering fluids, household cleaners and polishers, heating and cooking fuels, laundering items, art supplies, and toys containing chemicals.

SAFETY MEASURE

The proposed law would serve as a guide for writing regulations requiring labels to show such information as the products, contents, possible dangers, directions for safe use and first aid instructions. It is intended to reduce careless and ignorant handling and storage of chemicals in the home, in small businesses and in other areas where control of exposure is not as efficient as it is in the manufacturing process.

The law would be an "enabling act" under which later regulations could spell out necessary details for enforcement and compliance. Legislation, proponents said, should be flexible and not readily out of date.

This act, the Board said, would be a first step toward protecting the public from potentially dangerous household and commercial chemicals.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE policies are not terminated nor are benefits reduced because of age.

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MILWAUKEE WISCONSIN

PHYSICIANS URGED TO FILE PRENATAL FACT REPORTS

Form Developed by SMS Division Seeks Pertinent Data

MADISON — A special appeal to Wisconsin physicians, particularly those who practice obstetrics, to utilize and file a prenatal fact report developed by the S.M.S. Division on Maternal and Child Welfare was issued this month.

Dr. George S. Kilkenny, Milwaukee, Division Chairman, said:

"In providing this form, the Division wishes to encourage a closer working relationship between physicians and hospitals so that obstetrical patients presenting special problems can be given optimum care upon admission to the hospitals and prior to the arrival of the attending physicians.

"This form is not intended to supplant present hospital records but is intended to provide additional information of help to both the hospital and the physician."

ONLY $2

More than 300 physicians have ordered pads of 100 sheets, priced at $2. These may be secured from the Division on Maternal and Child Welfare, State Medical Society P.O. Box 1109, Madison.

In its report to the House of Delegates last May, the Division stated:

"Each physician is urged to utilize the proposed prenatal fact report to be filed with the hospital prior to delivery so that emergencies can be anticipated through prior knowledge of the patient's condition.

"It is further recommended that hospital staffs endorse this program and make it an obligation of individual staff members to provide such information on all obstetrical patients to be admitted."

FILE EARLY

Suggested procedure for the forms is to file at the hospital during the final month of pregnancy. If there are indications of possible premature delivery, doctors are urged to file sooner than the last trimester of pregnancy. The form is directed to the supervisor of obstetrics at the hospital to which the patient will be admitted.

The form seeks information on number of births, the kind, expected date of confinement, weight at onset of pregnancy, ideal weight, special problems, x-ray findings, evaluation of pelvic architecture, position of foetus, possible baby-feeding problems, possibility of abnormal birth and recommendations for special precautions to be taken.

Division members, in addition to Dr. Kilkenny, are Drs. Edward A. Birge, Milwaukee; Thomas V. Geppert, Amy Louise Hunter and Thomas A. Leonard, Madison; Fred G. Johnson, Superior; Albert H. Stahmer, Wausau; John D. Wilkinson, Oconomowoc and Kenneth J. Winters of Wauwatosa.

Special studies in maternal deaths, sponsoring of numerous institutes for review of maternal mortality, obstetric hazards and prematurity problems; methods to improve infant care, fetal-neonatal surveys, anesthesia and the possibility of expanding autopsies with active participation of pathologists are matters which are keeping this determined committee busy.

ON THE S.M.S. CALENDAR . . .

NOVEMBER

17—Division on Public Assistance and Division on Rehabilitation, S.M.S.

25—Executive Committee, National Blue Shield Plans, Seattle

27–30—A.M.A. Clinic Session, Seattle

27—Circuit Program Lancaster

28—Circuit Program, Janesville

29—Circuit Program, Appleton

DECEMBER

5—Division on Crippled Children, S.M.S.

5—Claims Committee, S.M.S.

8—Commission on Medical Care Plans, S.M.S.

14–15—Commission on State Departments, S.M.S.

14–16—General Council, S.M.S.

25—MERRY CHRISTMAS!

Mr. Starkweather

Starkweather Joins S.M.S. Staff

MADISON — Manning the new Blue Shield – Blue Cross mobile sales unit for the State Medical Society is Fred W. Starkweather, Milwaukee, who joined the staff this fall.

Starkweather, who saw four years of service with the U. S. Army Air Force during World War II, previously worked with a wholesale drug firm for eight years.

He is married and the father of five children.

PICK RED SERPENT AS MEDICAL SIGN

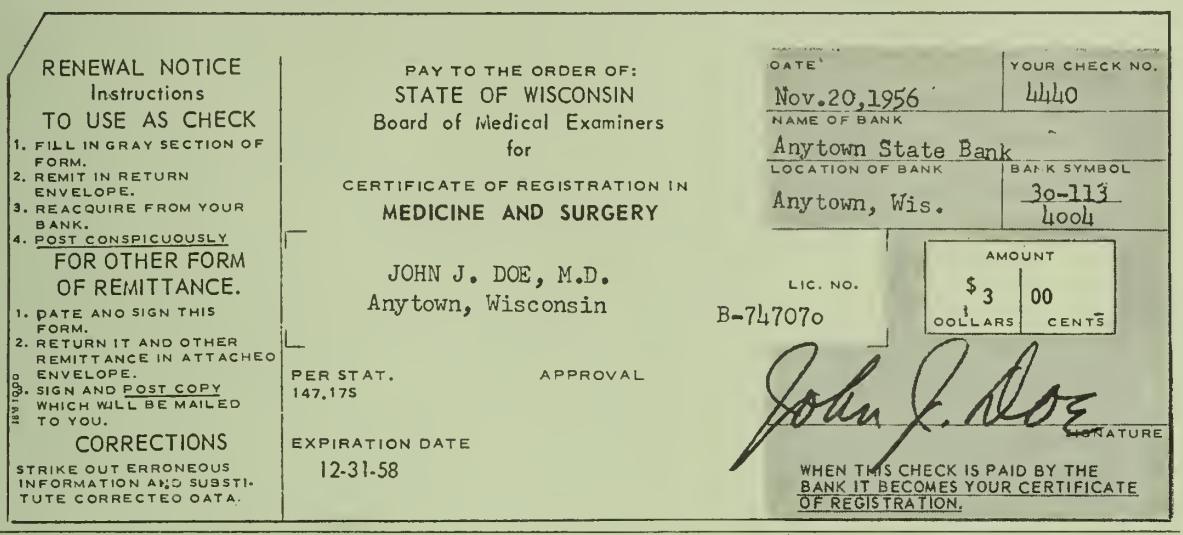
HAVANA, CUBA — The World Medical Association, meeting at its 10th general assembly here in October, approved a new emblem to be universally recognized in time of war for the protection of civilians engaged in medical work.

The new emblem is a red serpent and staff on a white background. It is formed by a sinuous line with three undulations coiled around a vertical stick.

PREPAREDNESS MOVE

Future wars, WMA delegates agreed, may involve bombing of civilian populations and the protection of civilian medical personnel, ambulances and hospitals taking care of civilians would be of major importance.

The new emblem is expected to serve the same function for civilians as the Red Cross emblem does for military personnel engaged in medical work.



RENEWAL NOTICE
Instructions
TO USE AS CHECK
1. FILL IN GRAY SECTION OF FORM.
2. REMIT IN RETURN ENVELOPE.
3. REACQUIRE FROM YOUR BANK.
4. POST CONSPICUOUSLY
FOR OTHER FORM OF REMITTANCE.
1. DATE AND SIGN THIS FORM.
2. RETURN IT AND OTHER REMITTANCE IN ATTACHED ENVELOPE.
3. SIGN AND POST COPY WHICH WILL BE MAILED TO YOU.
CORRECTIONS
STRIKE OUT ERRONEOUS INFORMATION AND SUBSTITUTE CORRECTED DATA.

PAY TO THE ORDER OF:
STATE OF WISCONSIN
Board of Medical Examiners
for
CERTIFICATE OF REGISTRATION IN
MEDICINE AND SURGERY

JOHN J. DOE, M.D.
Anytown, Wisconsin

PER STAT. 147.175
APPROVAL
EXPIRATION DATE
12-31-58

DATE Nov. 20, 1956
YOUR CHECK NO. 4440
NAME OF BANK Anytown State Bank
LOCATION OF BANK Anytown, Wis.
BANK SYMBOL 30-113 4004
LIC. NO. B-74707o
AMOUNT $3 00 DOLLARS CENTS
John J. Doe SIGNATURE
WHEN THIS CHECK IS PAID BY THE BANK IT BECOMES YOUR CERTIFICATE OF REGISTRATION.

M. D. REGISTRATION RENEWALS ARE DUE BEFORE JANUARY 31!

MADISON — Wisconsin physicians have been urged by the Wisconsin Board of Medical Examiners to file a renewal certificate of registration, in accordance with law, before January 31.

Renewal notices are being sent this fall to those holding state licenses. In the form of a check, it requires only the physician's signature, the date, check number, name of bank and its address and the bank symbol.

Using this form (shown above), the Board said, will make it possible to give better, faster service. It facilitates handling of cash receipt and registration records, next year's form and the annual registration. Physicians, however, may remit payment by personal check, bank draft or money order, if they prefer. They are still required to fill out the renewal blank and return it with their check of $3.

Physicians serving in the Armed Forces, completely retired, or practicing out-of-state or in federally-operated institutions are not required to pay the registration renewal fee, but must do so if they wish their names included in the 1957 registry. Regardless of whether the fee is paid, the card must be returned, indicating the address of office.

When the renewal form is cancelled as a check and returned to physicians by their banks, it will serve as an official certificate of registration.

Rock County Assistants Install New President

BELOIT—*Audrey Holtshopple, Janesville, was installed as president of the Rock County Medical Assistants Society at a recent meeting of the affiliate of the Wisconsin Medical Assistants Society.*

TAKES OFFICE

Miss Holtshopple succeeded Esther Bittrich, Beloit, who serves as publicity chairman for the state organization.

Other new officers:

Lois Dill, Beloit, president-elect; Marise Moe, Janesville, corresponding secretary; Claudine Doubleday, Beloit, recording secretary and Gwen Selchert, Janesville, treasurer.

The Rock County group was one year old in October.

CANADIAN GOLF CONCERNS EDITOR

MADISON — Just to prove that "*our northern neighbors also are subject to criticism,*" **Dr. Robert G.** Zach, Monroe, sent in the following, clipped from an Ontario, Canada, newspaper:

"Particularly on Wednesdays, we'd say, it's sometimes next to impossible to find a doctor anywhere in this area. In their offices, that is, or at the hospitals. No one would deny the medics their relaxation, but it has often been remarked that they could do a better job, give better service to the public, if they rotated their relaxation.

"Or are they averse to playing golf with anyone but fellow M.D.'s?"

Dr. Zach added:

"It was on the front page of the paper, too."

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
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Our helpful brochure
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available on request.

WHITEWATER—A portion of the audience attending one of four workshops at the Conference on School Health here October 18 is shown above. The panel was discussing "Putting Preventive Mental Health Concepts to Work in the School." Physician members of the panel included Drs. Kenneth C. Bill, Elkhorn, and Harold J. Werbel of Delavan.—(Walt Peterson Photo)

MILITARY WILL PAY FOR EMERGENCY CIVILIAN CARE TO ACTIVE DUTY MEN

MADISON — The U.S. Armed Services has informed the State Medical Society it would process all claims for payment of medical bills incurred by active duty personnel who are admitted as emergency cases to civilian hospitals and treated by civilian physicians.

First Lt. Thomas J. Campbell, of the U.S. Air Force, adjutant for the 327th Infirmary at Truax Field, said the normal procedure for a hospital or a private physician to follow after treating a military man is to submit the bill to the nearest military installation of the service that the patient is in.

For example, in the Madison area for Air Force personnel, the Commander of the Truax Field Infirmary would process the bill. For Navy personnel, the Commander of the U.S. Naval Hospital at Great Lakes, Ill., would handle the matter, and for Army personnel, the Commander of the U.S. Army Dispensary at Ft. Sheridan, Ill.

To expedite matters, First Lt. Campbell suggested that physicians list the name and service number of each patient, his rank, organization and base to which assigned.

Government regulations require the payment of claims for medical treatment be made all at one time. For example, if a military man is hospitalized in a civilian hospital after an accident, and is treated by a physician, the bill from the hospital and the doctor must be processed for payment at the same time.

This fact, First Lt. Campbell explained, is usually the cause for any delay encountered in paying bills submitted by civilian physicians or hospitals.

CO-OP HEALTH GROUP CHANGES ITS NAME

PHILADELPHIA, PA.—The Cooperative Health Federation of America, a national organization of consumer-sponsored health plans, voted at its annual meeting this fall to change its name to **Group Health Federation of America.**

The action is subject to approval by member plans. Nearly all the member plans operate under the non-profit rather than cooperative laws.

The Federation was founded at Two Harbors, Minn., in August, 1946, and proposed to direct and coordinate cooperative health plans on a national basis. At that time the group adopted a resolution *"approving the principle of public responsibility for assuring the availability of health and medical services for all people, without economic barriers and supporting proposals for larger grants to the states for public health purposes and nationwide health insurance under public auspices."*

The 1957 meeting will be held in Two Harbors.

Ask for Statewide School Health Meeting in 1958

WHITEWATER — The State Medical Society's Division on School Health recently voiced a desire to foster a statewide conference on school health in 1958 or 1959.

Meeting here in conjunction with a regional Conference on School Health at Wisconsin State College, Whitewater, the Division also expressed willingness to work with local groups in staging health conferences in the next few years.

A Conference on School Health at Superior November 15 concluded a series of nine held on college campuses since 1953.

Dr. E. H. Pawsat, chairman of the Division, said he thought key persons in each county should be invited to the state conference which would embody all current problems, trends and programs.

"Over-Specialization" Hit by U.S. Jurist

WASHINTON, D.C. — U.S. Supreme Court Justice Felix Frankfurter told Georgetown University medical students recently that doctors "can become too specialized—they become confined in the narrow grooves of their calling.

"Medical specialization is necessary," he said, "but specialization is mutilation of the whole.

> *"The professional man must go beyond even the broadest horizons of his own field—the 'boundaries of knowledge'—and take an interest in life itself.*
>
> *"Medicine has taken a position as a 'social enterprise' and cannot be regarded solely as part of private enterprise."*

"PRIVATE MATTER"

The idea that medicine is entirely a private matter between a physician and his patient is "totally discredited by all we know, but I would not presume to outline what the relationship should be," the jurist said.

He took a jab at the A.M.A. when he commented briefly:

"I should be a little troubled if my profession hired an advertising agency to work out its relations with the government. In saying this, I do not intend to 'exculpate' the law profession."

Education Not Resulting in "Cancerphobia," Survey Shows

Madison—Cancer education is not being over-stressed and is not resulting in "cancerphobia," a survey conducted by the University of Wisconsin Tumor Clinic revealed recently.

Drs. Robert Samp and Anthony Curreri interviewed 560 persons on their attitudes toward cancer education. They said they had learned most patients and their families do not fear the disease, want to know more about it and think cancer education saves lives.

Fully 85 per cent of those surveyed felt they knew more about cancer than did their parents, 94 per cent agreed that fear of cancer was reduced by explanations offered in educational programs, 96 per cent said education aided early diagnosis and 98 per cent said cancer education helps save lives.

"The educational programs seem to be stimulating an awareness, an alertness or consciousness in maintaining good health," Dr. Samp said.

Thirty per cent of those interviewed felt that cancer education was not reaching people who need it most, in rural areas and small communities. Eighty per cent said they wanted to be told if they had cancer, a large proportion said they considered cancer curable and 90 per cent said they thought so because of cancer education.

The random sampling covered both rural and urban groups in all sections of the state.

Two Physicians Named To New State Body

MADISON — Gov. Kohler, acting on a suggestion made by Dr. Arthur W. Hankwitz, Milwaukee, has taken steps to create a 11-member State Nautical Commission.

Dr. Hankwitz, a boating enthusiast, proposed that the Commission be created "to assemble and formulate proper over-all material to be included in legislation on the subject of navigation in state waters."

Dr. C. Darwin Jurss, Milwaukee, was named to the Commission, as was Dr. Hankwitz.

Listen to the "March of Medicine" on any one of 42 Wisconsin radio stations every week.

Learn Human Relations As Well As Medicine, U. W. Freshmen Urged

MADISON — Freshmen medical students were urged to become experts in human relations as well as modern medicine by University of Wisconsin Pres. E. B. Fred.

Speaking at an orientation program for medical students, Dr. Fred told the future physicians to become active members of the university community.

He said:

"Although your eyes may be sore from texts and technical reading, take the time to scan an occasional novel, and do not neglect the classics. Devote some time to art, music, philosophy and politics.

"LIFT YOUR EYES"

"In short, while becoming an expert in one of the demanding fields of knowledge, lift your eyes from the microscope long enough to see the world in naked eye dimensions."

Dr. John Z. Bowers, dean of the Medical School, said the freshmen orientation is a new attempt to answer some of the questions and to remove some of the doubts in the minds of the newcomers.

Other speakers explained the aspects of medicine on the state and national level.

Start New Phase Of A.M.A. Medical Services Survey

CHICAGO—What does the hospital patient get for his money?

The answer to that question is being sought in a survey conducted by the A.M.A. as the second phase of a three-part, five-year study measuring the medical services given to the American people by their physicians. *Services will be measured, not the money spent.*

Persons discharged from hospitals in the third week of October will be queried. More than 7,000 hospitals have received questionnaires which will attempt to learn the age, sex, length of stay and diagnoses for every hospitalized person discharged during this period. Other questions concern the nature of the ailments or conditions, number of beds used by accident casualties, by pregnant women, by patients undergoing non-emergency surgery.

RECIPIENTS OF SMS STUDENT LOANS GRATEFUL

MADISON — How do recipients of student loans from the State Medical Society and its Charitable, Educational and Scientific Foundation feel about this service?

One young physician, doing his residency in Milwaukee, wrote:

"I hope that some day I will be a contributor to the fund that helped me so much. The loan was an invaluable aid to me. I am very appreciative of your help, and very happy with your interest in me."

Another said:

"It was extremely gratifying to receive a loan from the Fund when I did. I appreciate the interest in its members by the Society."

Other letters voice the same sentiment.

Loans totaling $24,410 have been made to 19 University of Wisconsin medical students and to 13 at Marquette University. The average loan was $763.

The program started in 1951, with the wholehearted backing of the Society's General Council.

The Foundation has authorized an annual cash award for an outstanding scientific paper prepared by a physician doing his residency in Wisconsin. Details will be announced in the near future.

Another matter relating to medical students is development of a Senior Medical Student Day to be held at Marquette and Wisconsin next spring. April 22 will be the date of the Milwaukee meeting; the date at Madison is still to be determined. Senior students and their friends will be invited to a short program relating to finding and establishing a practice and some of the personal, insurance and business problems a new physician encounters.

CHIRO LOSES STATE LICENSE

MADISON—The State Board of Examiners in Chiropractic recently suspended the Wisconsin license of E. P. Riess, Sheboygan, for an indefinite period for *"unprofessional conduct and unprofessional advertising of a character likely to deceive and defraud the public."*

Riess will be eligible to apply for reinstatement next July 1.

His license was suspended for a four-month period in 1953.

Physicians Selected For New Committee

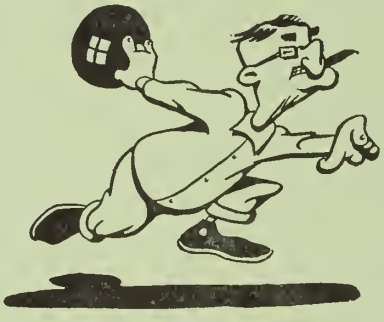
MADISON — Dr. Marvin H. Olson, Wittenberg, an active worker in the U.S. Committee Inc. of the World Medical Association, recently named three members of the State Medical Society to a state committee of W.M.A.

They are:

Drs. E. L. Bernhart, Milwaukee; Sarah Rosekrans, Neillsville and John Buesseler, Madison.

Dr. Olson said the medical schools at Marquette University and the University of Wisconsin would be asked to appoint advisory members to the state committee, with the president and president-elect of S.M.S. serving as ex-officio members.

LIKE TO BOWL?



WISCONSIN RAPIDS—Like to roll 'em, Doctor? Here's your chance to do just that, with other doctors.

The First Annual STATE MEDICAL SOCIETY PHYSICIANS' BOWLING TOURNAMENT will be held in Wisconsin Rapids on Saturday afternoon, February 2.

There'll be a tournament for the ladies at the same time.

Competition for the doctors will be in both singles and doubles events. If your average is 150 or over, you'll be in the "Experts" class. If you usually hit below that figure, you'll be bowling with other "Duffers." Pairings will be made prior to the tournament, if entries are sent in sufficiently early.

The ladies will bowl in singles competition, in one free-for-all class.

Prizes will be awarded for the top scores.

The Wood County Medical Society plans a party for the participants after the rolling is concluded at the Bowlmor Recreation Alleys, two miles south of Wisconsin Rapids on Highway 13.

If you plan to attend—and the success of the tourney depends on your participation—**do two things:**

First—Send in the coupon below to the STATE MEDICAL SOCIETY, Box 1109, Madison. (It'll help the planning committee if you send it in soon).

Second—Make your hotel or motel reservations in the near future if you plan to stay over. The Mead Hotel reports it'll have a large number of rooms available.

HERE'S ANOTHER ENTRY: (Please Print)

MEN'S SINGLES _____

MEN'S DOUBLES _____

(Name of partner) _____,M.D.

My name is _____, M.D.

My average is _____

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My Lady plans to bowl, too.

Mrs. _____

CAREFUL INSPECTION—is given a microscope donated to S.M.S. by Dr. Ludwig A. Schoen. Inspecting the instrument are four University of Wisconsin Medical students who are working part-time at the Society headquarters in Madison. Holding it is Don Pritzl, whose home is in Marshfield. Others (left to right) are Fred Melms, Milwaukee; Bob Taake, Manitowoc, and David Ottensmeyer of Superior.

Foundation Loans Microscope to Medical Student

MADISON — The importance of contributions to the S.M.S. Charitable, Educational and Scientific Foundation Inc., was brought out recently when the Society was able to fill the request of a medical student who needed a microscope.

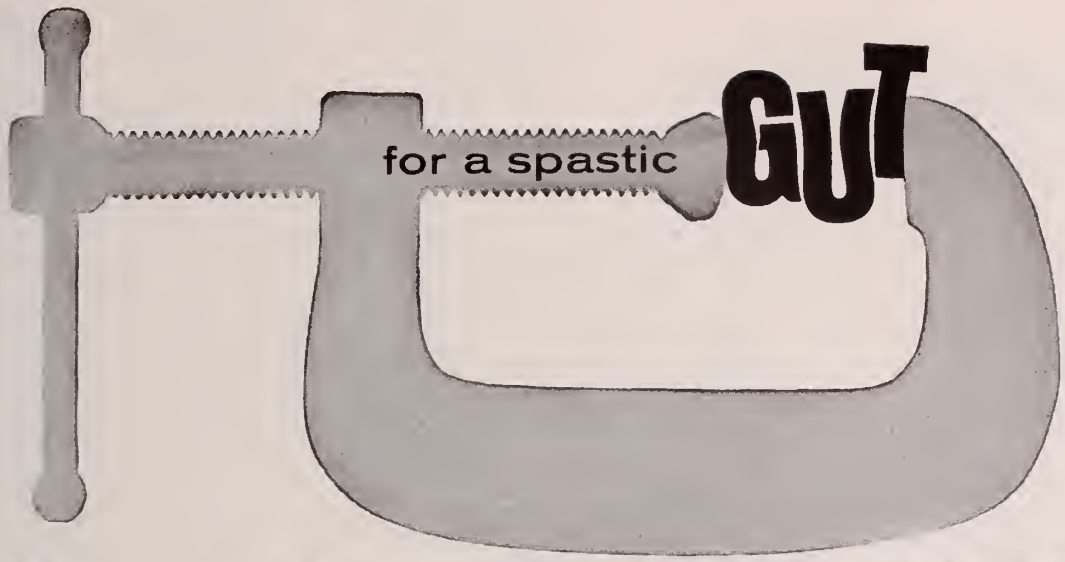
This summer **Dr. Ludwig A. Schoen**, Wausau, who has not practiced since 1937, donated a fine microscope to the Foundation. Some needy medical student, he said, should be able to make use of it.

NEED APPARENT

The request came from a Milwaukeean attending the Washington University School of Medicine in St. Louis. He asked for either a microscope or a loan to purchase one. The Foundation is restricted to making loans to students studying in Wisconsin.

Just a few weeks ago, **Dr. James P. Conway**, Milwaukee, presented his microscope to the Foundation. It will be cleaned and refurbished, and then made available on a similar arrangement.

Plates showing the source of the donations will be attached to the instruments.



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This case report is from the files of a general practitioner.

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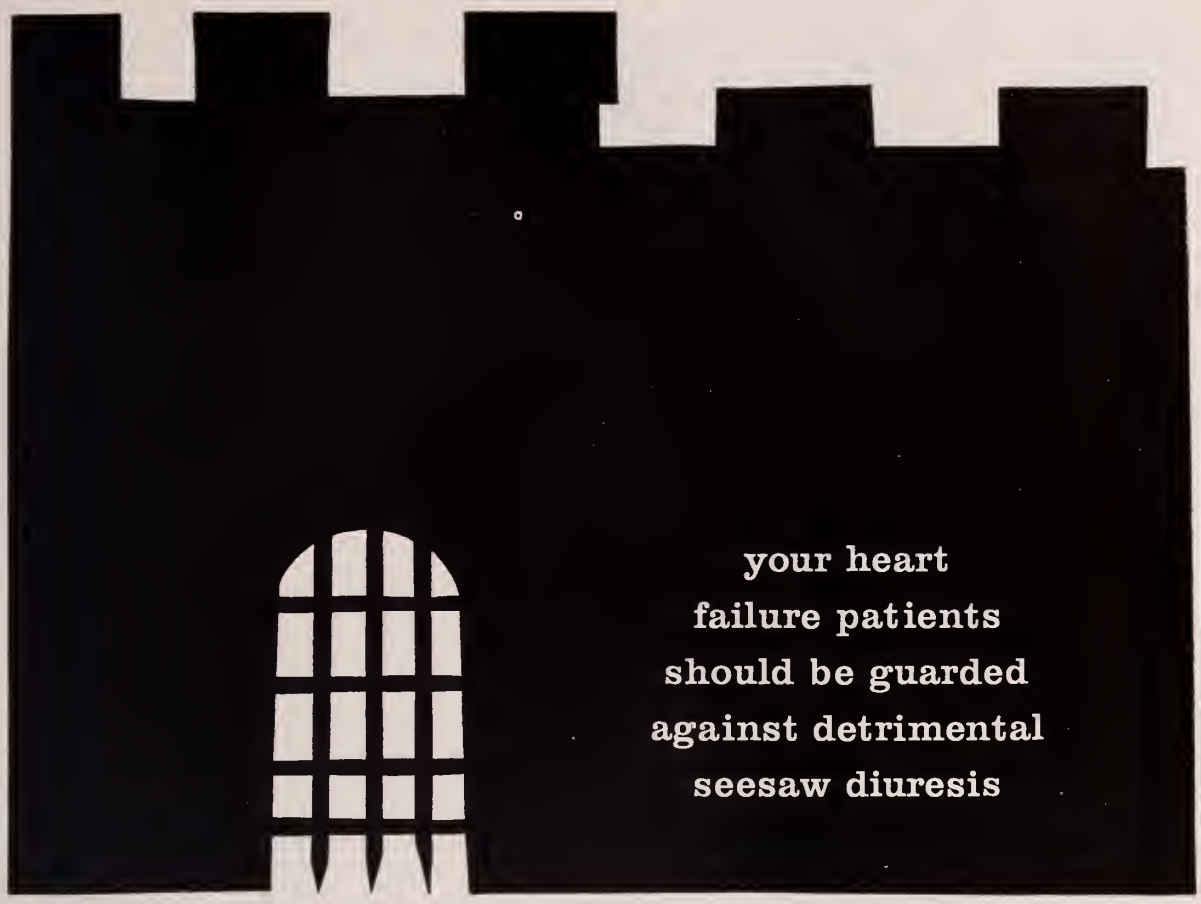

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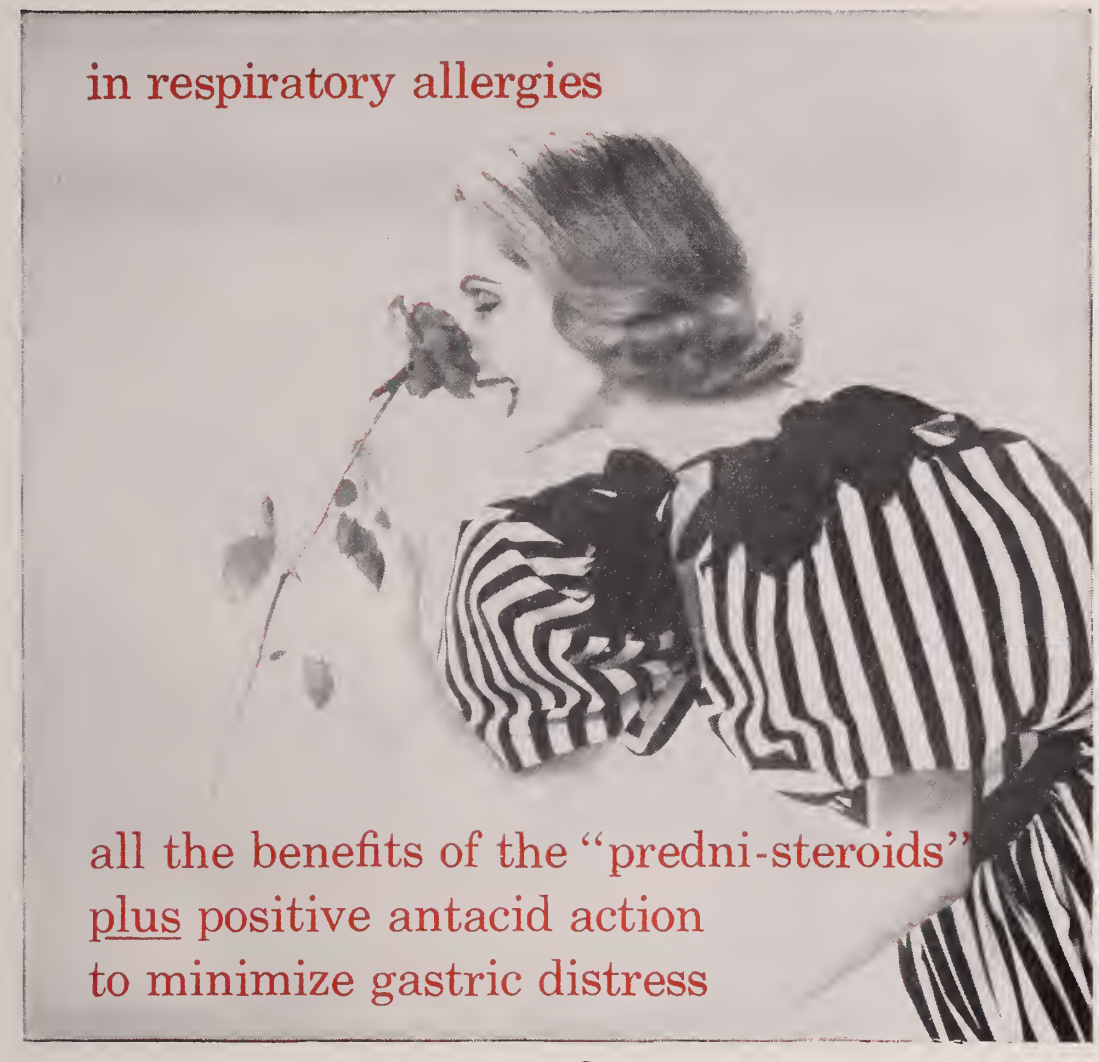

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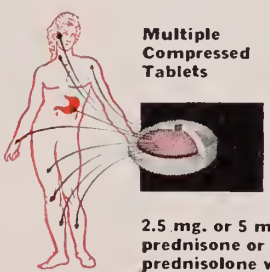

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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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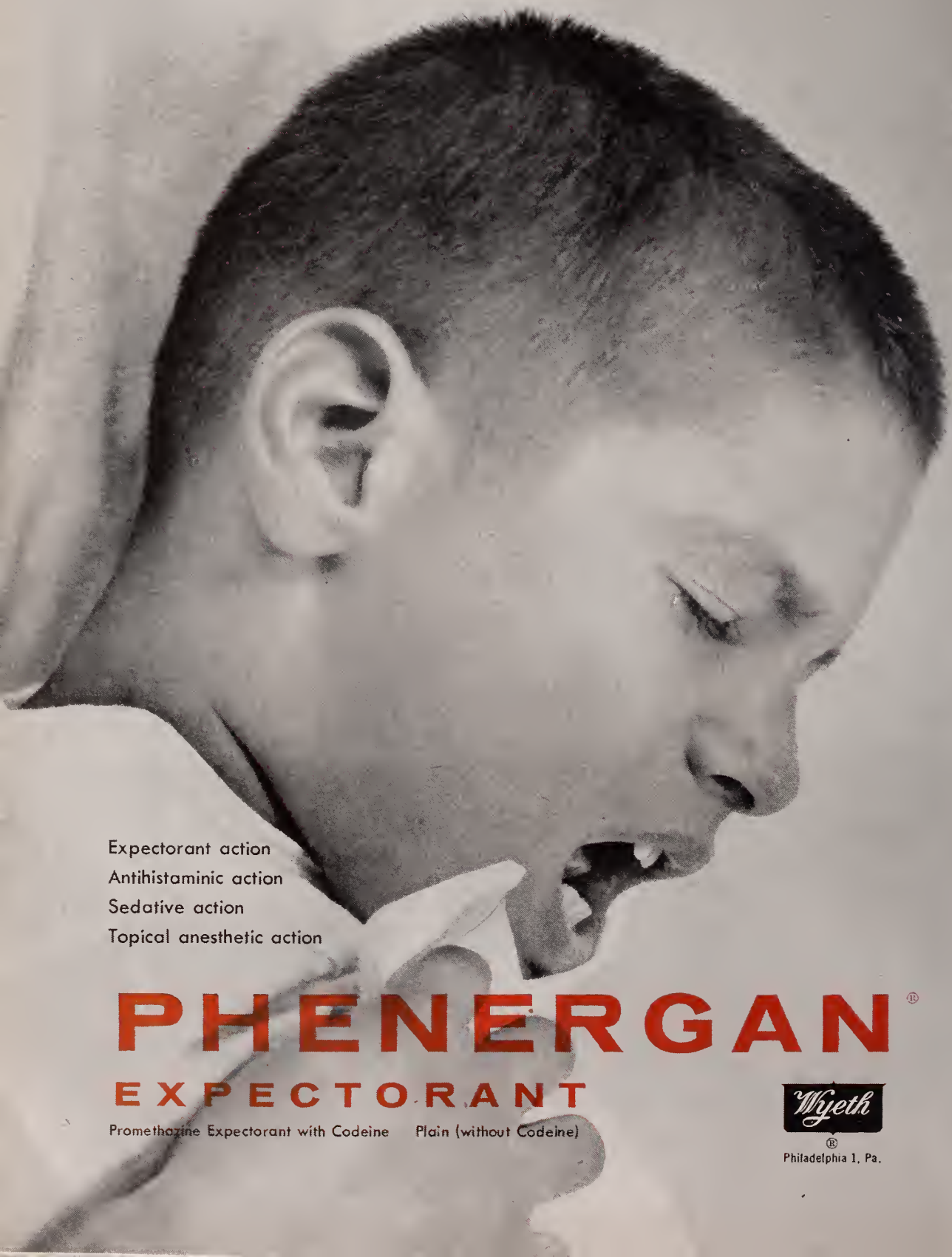

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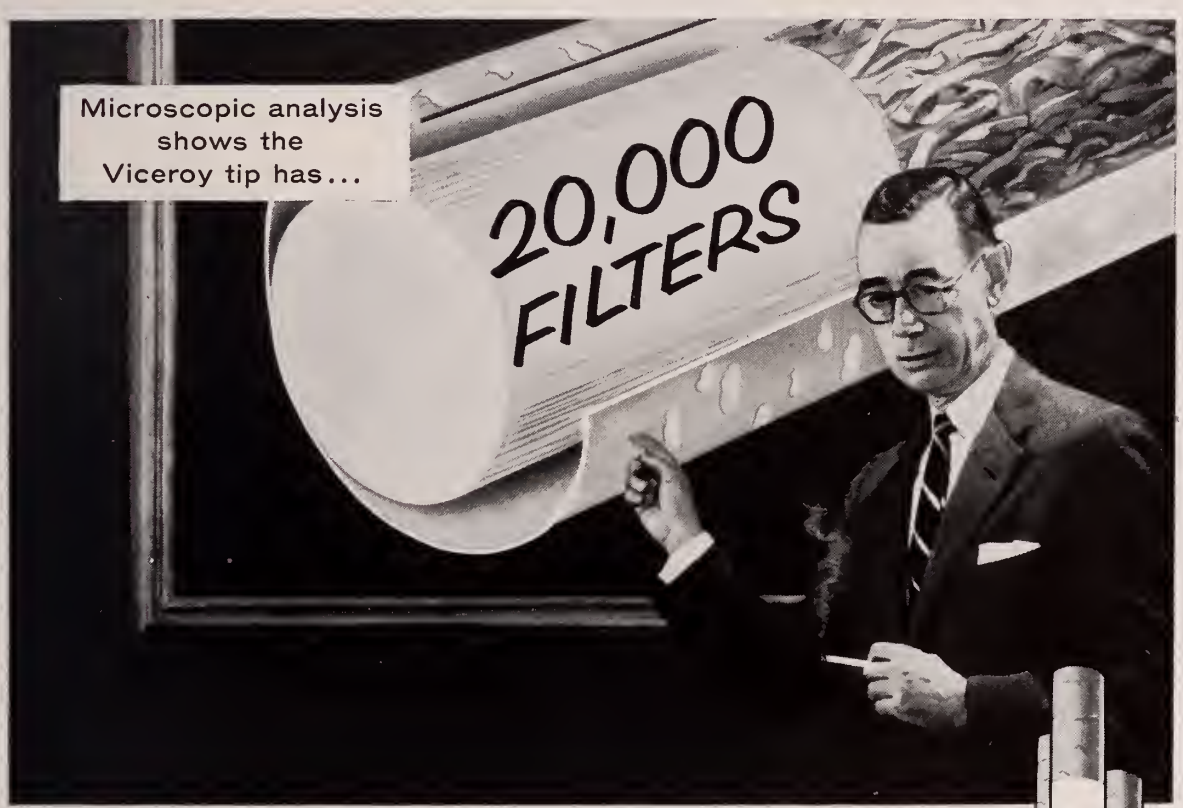

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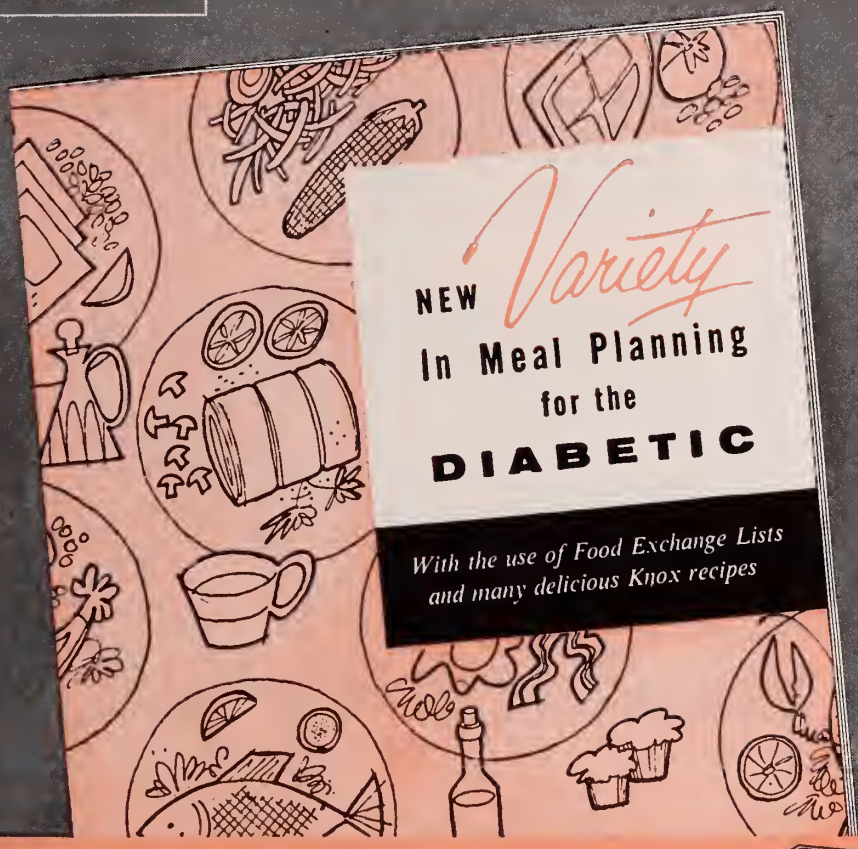

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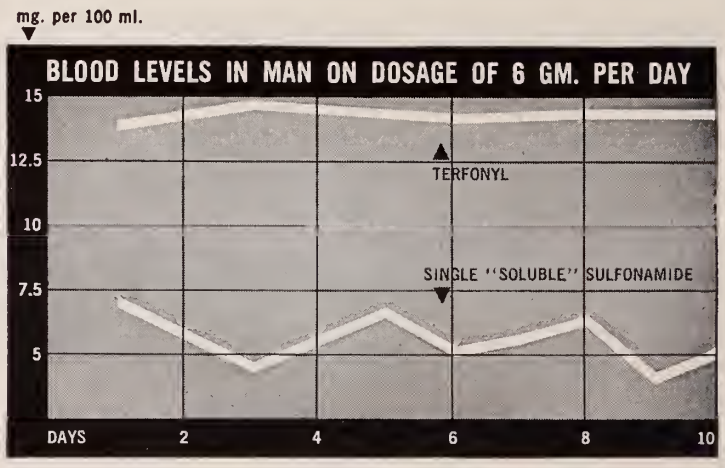

— After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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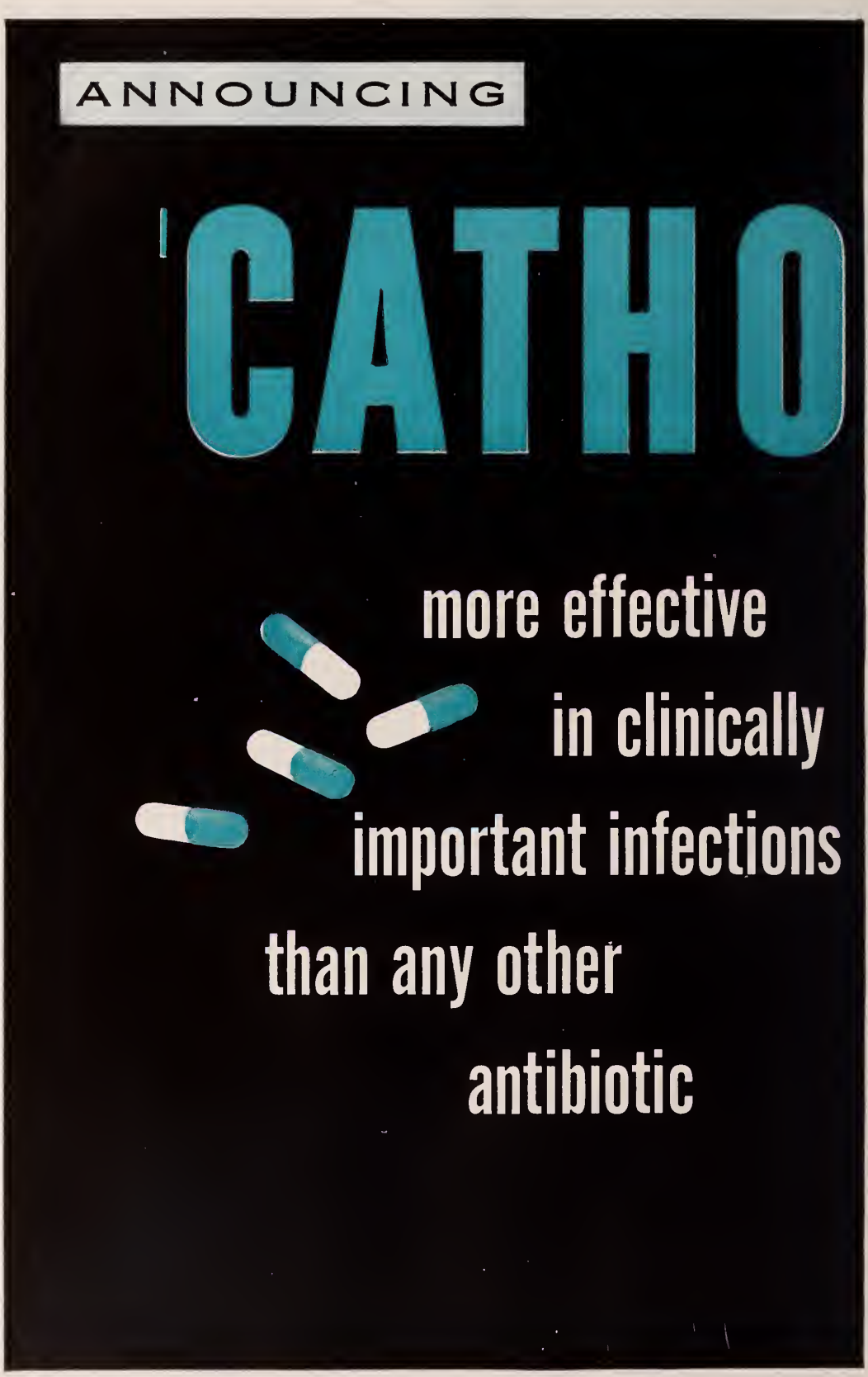
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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

This Pace is Not Killing Us. By J. I. Rodale, Emmaus, Pennsylvania, Rodale Press, Inc., 1954. Price $1.00.

This is a very brief work on the subject of the prevalence of heart disease as a cause of death. The author claims that we have been deluded into thinking that heart disease is increasing because of the excitement and tension and what he calls "pace" of our present everyday life. He cites statistics and opinions which would tend to prove that our forebears were under even greater tensions than we but that fewer of them died of heart disease.

Finally, he expresses opinions that the two main things wrong with the world today, both of which are causing heart disease, are: 1. A poor diet in the midst of plenty, and 2. The excessive use of tobacco. He makes further claim that the reason for the poor diet is the refinement of food production and the addition of chemicals which destroy vitamin content.

Whether intentionally or otherwise, the author completely overlooks the lowered death rate from infectious diseases, which is giving us an aging population. Although his main subject is heart disease, he does take an occasional flyer into such side channels as peptic ulcer and the prevalence of juvenile delinquency. He ends up by chastising American scientists for studying space travel and the blood pressure of giraffes in Africa rather than tackling the basic dietary problem.

It is the opinion of the reviewer that the best attribute of this book is its brevity. It can be read in a very short time; hence, not much time need be wasted with it. In general, the sentence structure is mediocre; and there are many places where the author fails to make points or to properly introduce a subject. The strength of the book consists of its quotations, which are taken from many men of scientific intellect and, fortunately, are quoted verbatim. I could not state that I found the book to be stimulating in any way.—R. C. P.

Reactions with Drug Therapy. By Harry L. Alexander, M. D., Emeritus Professor of Clinical Medicine, Washington University Medical School; Former editor of the *Journal of Allergy.* Philadelphia and London, W. B. Saunders Company, 1955.

This book is written by one of the pioneers in the field of allergy. It is clear, concise, and authoritative. It lists the various drugs as well as the frequency and types of reactions caused by them. It is a must for all who are interested in drug reactions and should be a most valuable addition to any library, personal or otherwise.—S.B.C.

Clinical Biochemistry. By Abraham Cantarow, M. D., Professor of Biochemistry, Jefferson Medical College, Formerly Associate Professor of Medicine, Jefferson Medical College, and Assistant Physician, The Jefferson Hospital, Philadelphia; and Max Trumper, Ph. D., Formerly Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School, National Naval Medical Center, Bethesda, Maryland. Fifth Edition. Philadelphia and London, W. B. Saunders Company, 1955.

The fifth edition of this book represents a useful and well-organized presentation of the biochemical aspects of disease. While this edition has only 75 pages more of text than the previous edition, it has been essentially rewritten and incorporates most of the present-day biochemical concepts. The authors have succeeded in culling the vast literature of biochemistry and medicine and present the clinician, for whom this book would be most useful, with an integrated picture of the two disciplines. There is some discussion of basic biochemistry in addition to its implications in and applications to diseased states which will prove most useful to the clinician. The text has an easy readability, partly because of the freedom from mere encyclopedic tabulation of data. The authors provide a number of simple but useful diagrams which represent metabolic interrelationships. The book is practically free of chemical formulae. While this will deny the reader the opportunity to understand the true biochemical basis of disease, it will provide the vast majority of clinicians with a dynamic verbal picture of present-day concepts and trends in this field.

The book has a good index (100 pages) which insures ready access to detailed information. The bibliographic references at the end of each chapter are not as complete nor, perhaps unavoidably, as up to date as they might be.—P.P.C.

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DERMATOLOGY

J. Edward Berk, M. D., Detroit, Mich.
GASTROENTEROLOGY

Erle Henriksen, M. D., Los Angeles, Calif.
GYNECOLOGY

Ovid O. Meyer, M. D., Madison, Wis.
INTERNAL MEDICINE

Irvine H. Page, M. D., Cleveland, Ohio
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Barnes Woodhall, M. D., Durham, N. C.
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John E. Savage, M. D., Baltimore, Md.
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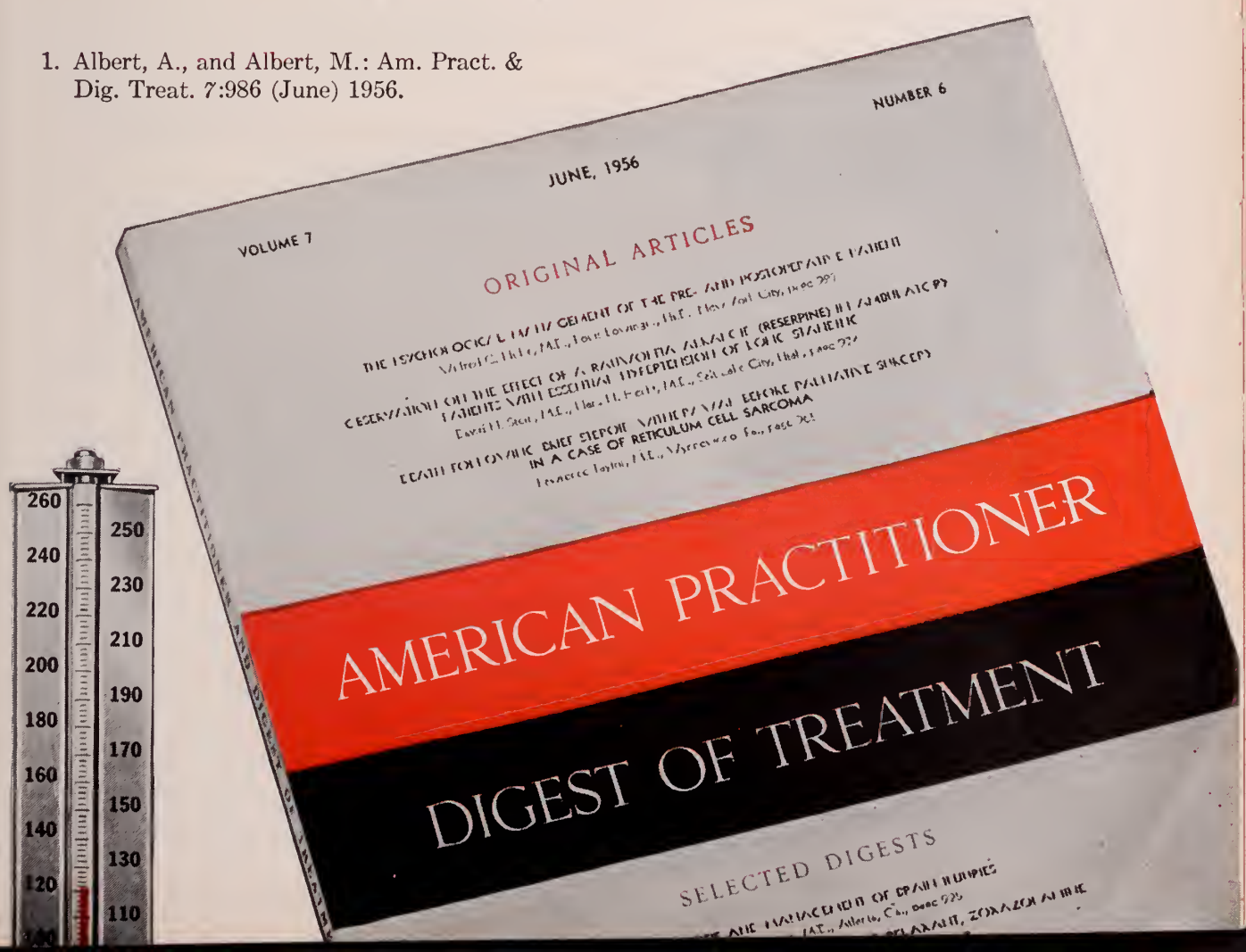
1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



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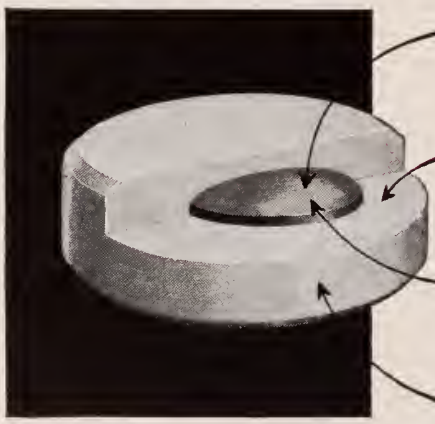

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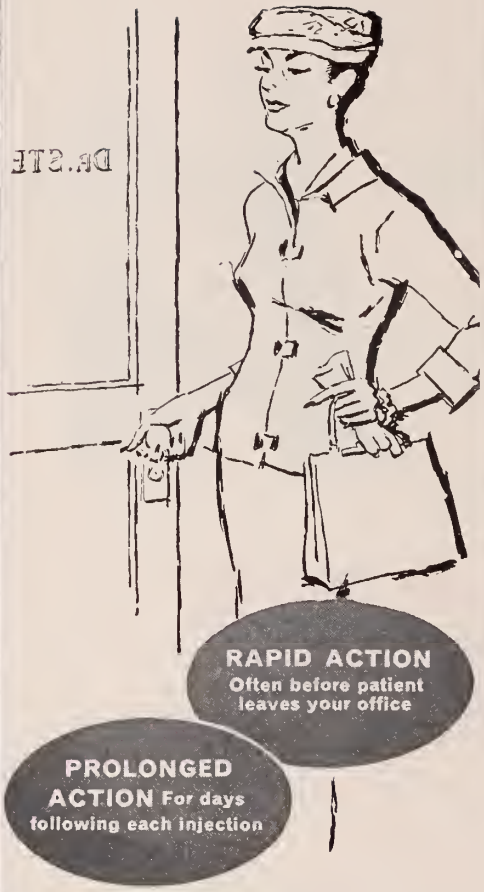

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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	1168, 1169
American Meat Institute	1177
Atlas Pharmaceutical Laboratories	1260
Ayerst Laboratories	1251
Baker Laboratories	1178
Barr X-Ray Company	1248
Bayer Company	1172
Benson Optical Company	1234
Brown and Williamson Tobacco Corp.	1253
Burroughs Wellcome & Co., Inc.	1171, 1232, 1233
Canada Dry	1265
Chicago Medical Society	1231
Ciba Pharmaceutical Products	1243
Cook County Graduate School of Medicine	1157
Corn Products Company	1247
Davies, Rose & Co., Ltd.	1261
Doerflinger Artificial Limb Co.	1248
Endocrine Laboratories	1174
Foot-so-Port Shoe Company	1251
Geigy Pharmaceuticals	1176
Gyne-Cytology Laboratory	1267
Hotel Schroeder	1228
House of Bidwell	1267
Hurley X-Ray Company	1251
Ivanhoe Sanitarium	1228
Keeley Institute	1267
Kennedy Mansfield	1156
Knox Gelatine	1257
Lakeside Laboratories	1174, 1245, 1248
Lederle Laboratories	1210, 1211, 1246, 1259
Lilly, Eli and Company	1182
Mallard, Incorporated	1272
Mallatt Pharmacy	1156
Mather Pharmacy	1156
Medical Protective Company	1157
Merck, Sharp & Dohme	1164, 1165, 1179, 1249, 1262, 1263, 1270, 1271
Milwaukee Sanitarium Foundation, Inc.	1276
New Orleans Graduate Medical Assembly	1267
New York Polyclinic	1243
Orthopedic Appliance Company	1243
Parke, Davis and Company	1154, 1155
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	1159, 1160, 1161, 1162, 1254, 1255
Physicians and Hospitals Supply Co.	1268
Physicians Casualty Association	1261
Professional Business Service	1239
Rennebohm's	1156
Robins, A. H., Co., Inc.	opposite 1258
Rogers Memorial Sanitarium	1276
S. and L. Signal Company, Inc.	1243
Sacred Heart Sanitarium	1256
St. Croixdale Sanitarium	1157
Schering Corporation	1166, 1167, 1180, 1181
Schmid, Julius, Inc.	1175
Searle, G. D. and Company	1225
Smith, Kline & French Laboratories	1163, 1244
Shorewood Hospital Sanitarium	1231
Squibb, E. R. & Sons, Div. of Mathieson Chemical Corp.	1258
Time Insurance Company	1237
Tutag, S. J., and Company	1248
Upjohn	1273
Wallace Laboratories	1170
Wine Advisory Board	1173
Winthrop Laboratories	1158, 1256
Wisconsin Neurological Foundation	1260
Wyeth	1174, 1250, 1269
Year Book Publishers, Inc.	1229

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	J. E. Kreher Ashland	J. M. Jauquet 220 7th Ave., W. Ashland	
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe Rice Lake	F. H. Goetsch Spooner	Second Tuesday 7:30 p.m.
Brown–Kewaunee–Door	Louis Milson 305 E. Walnut Green Bay	Frank Urban 305 E. Walnut Green Bay	Second Thursday*
Calumet	F. P. Larme New Holstein	Kenneth Humke Chilton	
Chippewa	F. J. Brown 116½ N. Bridge Chippewa Falls	B. J. Haines Cadott	Second Tuesday
Clark	J. W. Koch Colby	T. N. Thompson Neillsville	
Columbia–Marquette–Adams	H. Y. Fredrick Box 253 Westfield	F. W. Gissal 132 Washington Ave. Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	W. S. Cusick Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. S. Gearhart 621 S. Park Madison	T. V. Geppert 113 N. Carroll Madison	Second Tuesday Sept. through June
Dodge	R. I. Bender 147 Front Beaver Dam	M. E. Royce Mayville	Last Thursday*
Douglas	Conrad Giesen 1514 Ogden Superior	J. McGinnis 2231 E. Fifth Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	R. A. Buckley 131 S. Barstow Eau Claire	G. E. Wahl 616 E. Grand Eau Claire	Last Monday
Fond du Lac	Josephine N. Pallin 73 W. 12th Fond du Lac	Howard Mauthe St. Agnes Hospital Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	Charles Shields Fennimore	H. W. Carey Lancaster	Last Thursday, March, June, Sept., and Nov.
Green	F. J. Bongiorno Albany	D. E. Mings Monroe Clinic Monroe	
Green Lake–Waushara	A. J. Wiesender Berlin	G. C. Stone 124 N. Wisconsin Berlin	Last Thursday, every other month starting in Jan.
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	R. W. Quandt 1108 Main Jefferson	C. E. Quandt 804 Lincoln Ave. Jefferson	Third Thursday*

* Except June, July, and August

** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Juneau	J. H. Vedner Mauston	J. S. Hess Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. T. Garren 6124 Sheridan Rd. Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	A. A. Cook 1707 Main La Crosse	J. L. Jaeck 1836 S. Ave. La Crosse	Third Monday
Lafayette	L. L. Olson Darlington	R. E. Hunter Argyle	Last Tuesday
Langlade	W. P. Curran Antigo	J. E. Garritty Antigo	First Monday
Lincoln	F. C. Lane 401 W. Main Merrill	J. D. Millenbah Merrill	
Manitowoc	H. J. Belson 904 S. Eighth Manitowoc	R. J. Banker 709 Washington Manitowoc	Last Thursday
Marathon	E. B. Brick 501½ Third Wausau	J. V. Flannery 404 Third Wausau	
Marinette–Florence	R. J. Rogers Oconto	K. G. Pinegar 516 Houston Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	J. W. Fons Southgate 3333 South 27th Milwaukee	D. W. Ovitt 3300 W. Wisconsin Ave. Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	A. F. Slaney Oconto	F. E. Zantow Oconto	
Oneida–Vilas	T. M. Haug 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	A. C. Taylor 103 W. College Appleton	H. T. Gross 103 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	Frank Springer Elmwood	P. H. Gutzler River Falls	Third Tuesday
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Price–Taylor	E. B. Elvis Medford	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
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Walworth	G. A. Smiley Delavan	H. J. Werbel Delavan	Second Thursday*
Washington–Ozaukee	Kenneth Pelant Grafton	J. F. Walsh 125 E. Main Port Washington	Fourth Thursday
Waukesha	Albert Rogers Box 307 Oconomowoc	Phillip Wilkinson 618 W. La Belle Ave. Oconomowoc	
Waupaca	W. G. Arnold Clintonville	G. P. Dernbach New London	
Winnebago	J. T. Petersik State Hospital Winnebago	G. B. Hildebrand 216½ Main Menasha	First Thursday
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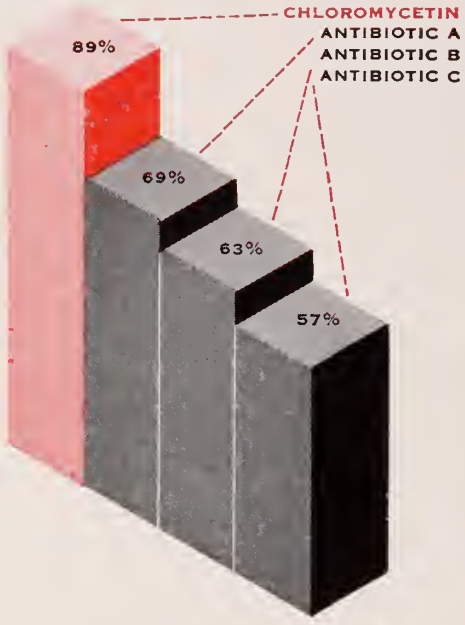

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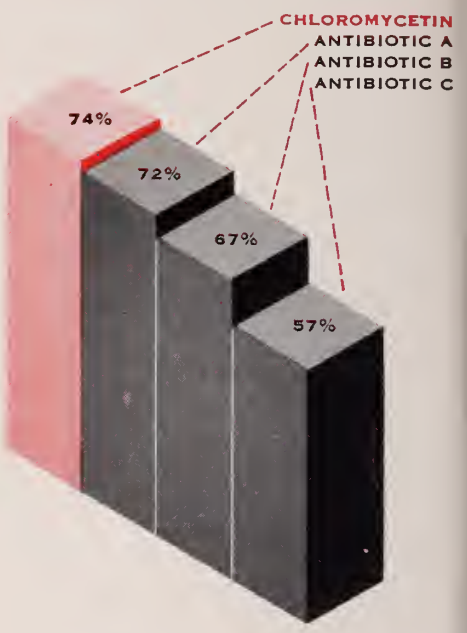

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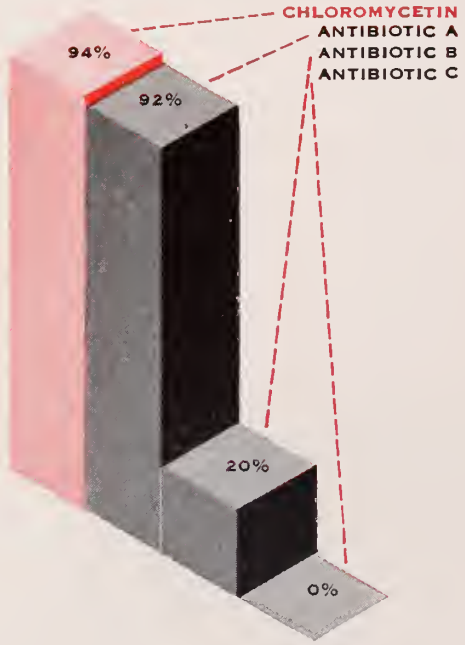

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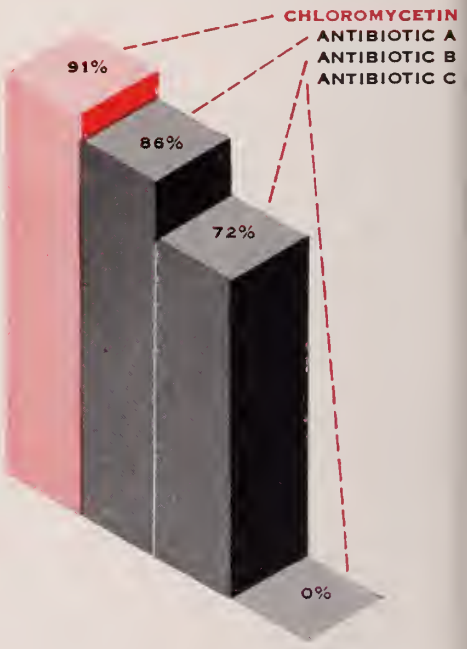

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on, Sherman, Cole,
n, & Fultz.[1]

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TABLE OF CONTENTS

SCIENTIFIC ARTICLES

	Page
Puerperal Inversion of the Uterus, by Elizabeth Allen Steffen, M. D.	1303
Problems in Intestinal Obstruction in the Neonatal Period, by Donald S. Thatcher, M. S. (Surg.), M. D., F.A.C.S.	1306
Fibrin Emboli of the Lungs With Afibrinogenemia After Cesarean Section, Without the Presence of Amniotic Epithelial Squames, by E. S. Olson, M. D.	1315
Autohemotherapy—An Effective Treatment for Herpes Zoster, by Fred J. Ansfield, M. D., and John L. Rens, M. D.	1319
Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists	1321
Services of District Health Officers	1324

MISCELLANY

Make Your Plans Now—Preliminary Announcement, 1957 Annual Meeting	1325
Official Call for Scientific Exhibits, 1957 Annual Meeting	1326
Minutes of the Council Meeting, Madison, February 25–26, 1956	1328
Minutes of the Council Meeting, Milwaukee, April 29, 1956	1336
Minutes of the Council Meeting, Land O'Lakes, July 28, 1956	1340
Minutes of the Council Meeting, Manitowish, September 7–8, 1956	1346
Minutes of the Council Meeting, Madison, October 27, 1956	1348
Facts About Wisconsin Physicians Service	1350
Gleanings from the Section on Medical History	1354
Society Proceedings	1357
News Items and Personals	1362
Third and Twelfth Districts News	1362
Society Records	1363
Obituaries	1364
Recent Wisconsin Licentiates	1370
Correspondence	1386
Physicians' Exchange	1388
Index to Advertisers	1390
Index, The Wisconsin Medical Journal, Volume LV, January, 1956–December, 1956	1393

EDITORIALS

Dependents' Medical Care	1351
The Best Physician	1352
Washington Forecast	1352
The President's Page	1353

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In the more than 12,000 cases treated with 'Compazine' here and abroad, and in experimental studies at very high dosage, no blood change or jaundice attributable to 'Compazine' was observed.

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For Pain-Fre

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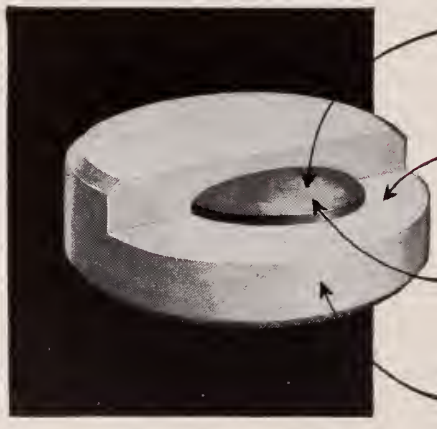

Physical separation of the steroid component from the aluminum hydroxide as provided by the Multiple Compressed Tablet construction assures full potency and stability of prednisolone.

PREDNISOLONE (1 m

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ASPIRIN (0.3 Gm.) .....

+

ASCORBIC ACID (50 n

+

ANTACID (0.2 Gm.) .....

*Early rheumatoid arthritis
Rheumatoid spondylitis
Osteoarthritis
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Tenosynovitis
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. . . . . for anti-inflammatory, anti-rheumatic benefits *at effective low dosage.*

. . . . . for analgesia plus additional anti-rheumatic activity.

. . . . . for anti-stress support that guards against adrenal ascorbic acid depletion.
(Ascorbic Acid present as 60 mg. Sodium Ascorbate.)

. . . . . dried aluminum hydroxide gel minimizes the possibility of gastric distress.

DOSAGE: *1-4 TEMPOGEN Tablets t.i.d. or q.i.d. (TEMPOGEN Forte, 1 or 2 tablets t.i.d. or q.i.d.) for one or two weeks. Then lower by 1 tablet every four or five days to maintenance level.*

SUPPLIED: *TEMPOGEN and TEMPOGEN Forte —in bottles of 100 Multiple Compressed Tablets. (TEMPOGEN Forte provides 2 mg. of prednisolone.)*

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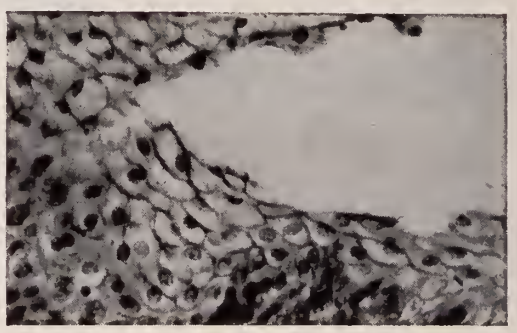
HOW VAGISEC LIQUID

PENETRATES

RECESSES OF VAGINA AND EXPLODES TRICHOMONADS OFTEN MISSED

Photomicrograph of section of epithelium of normal vaginal mucosa, enlarged 750 times, shows uneven surface where trichomonads hide. VAGISEC penetrates surface and explodes organisms in hard-to-reach areas.



TOO OFTEN AN ORDINARY trichomonacide fails to cure vaginal trichomoniasis because it has little or no effect on parasites that are not on the surface.[1] Trichomonads burrowed deeply into the roughened mucosa survive and set up new foci of infection. In fact, even a few hidden trichomonads remaining after treatment can cause acute exacerbations. With VAGISEC® liquid and jelly you can overcome this most troublesome problem.

Penetrates thoroughly — This new and unique trichomonacide spreads out and wets the entire vaginal surface. It rapidly dissolves mucinous materials, fats and blood clots.[1] It penetrates the cellular debris that lines the vaginal walls and shields the parasites, reaching trichomonads deep in their hiding places.

Explodes trichomonads — VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[2] Two surface-acting agents and one chelating agent combine to weaken the cell membrane, to remove the waxes and lipids, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

Proves highly effective — With the Davis technique† you can now rid patients of "trich," even cases that have resisted other treatment. VAGISEC liquid was developed as "Carlendacide," by Dr. Carl Henry Davis, M.D., noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical trials by more than 150 physicians show better than 90 per cent success.[3]

Use liquid and jelly — In the Davis technique, VAGISEC liquid is used in office therapy. At the same time, liquid and jelly are prescribed for home use. They are well tolerated, leave no messy discharge or stain.

Office treatment — Expose vagina with speculum and wipe walls dry with cotton balls. Then wash thoroughly with a 1:100 dilution of VAGISEC liquid. Remove excess fluid with cotton balls. Dr. Davis recommends six treatments.

Home treatment—Patient douches with VAGISEC liquid every night or morning and then inserts VAGISEC jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching contraindicated in pregnancy.

One course of treatment—"If the treatment has been accomplished as directed," the patient "will have no flagellates provided the infection was limited to the vaginal canal . . . A few women have infected cervical, vestibular or urethral glands and require other types of treatment."[4] Continued douching with VAGISEC liquid two or three times each week for eight to twelve weeks helps prevent re-infection.

Prevents coital re-infection — Infected husbands are ". . . a potential source of re-infection in wives successfully treated."[5] Prescribe for your patients the protection afforded by Schmid high quality prophylactics. Specify the superior RAMSES® rubber prophylactic, transparent, tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® prophylactic skins, of natural animal membrane, pre-moistened.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

References: 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. 68:559 (Aug.) 1954. 2. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955. 3. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Lanceley, F., and McEntegart, M. C.: Lancet 1:668 (Apr. 4) 1953.

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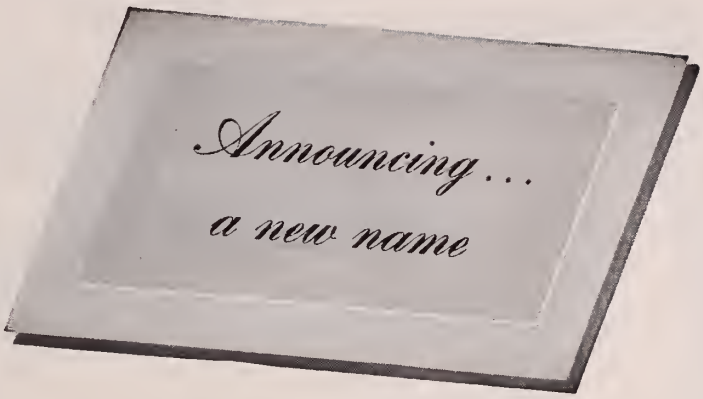

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to provide the unchanging safety and predictability afforded by the uniform potency, uniform absorption, brief latent period and optimum rate of elimination of this crystalline glycoside.

Tablets:	*0.25 mg. (white) and 0.5 mg. (green)*
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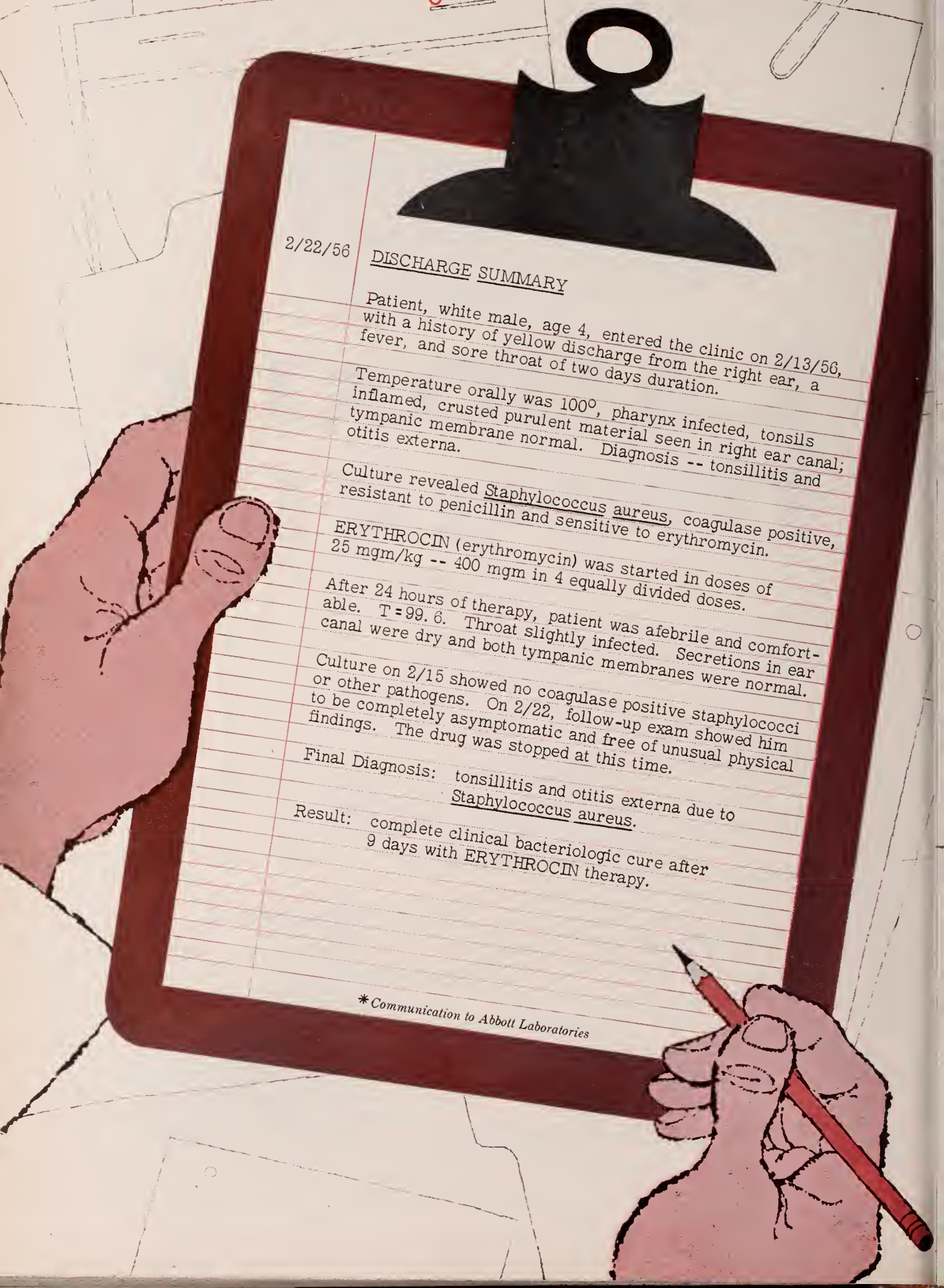
Erythrocin in treating tonsillitis and otitis externa*



2/22/56

DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: "*. . . the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbott

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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(Erythromycin Stearate, Abbott)

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NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.

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Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously **controls the symptoms and the apprehension**

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

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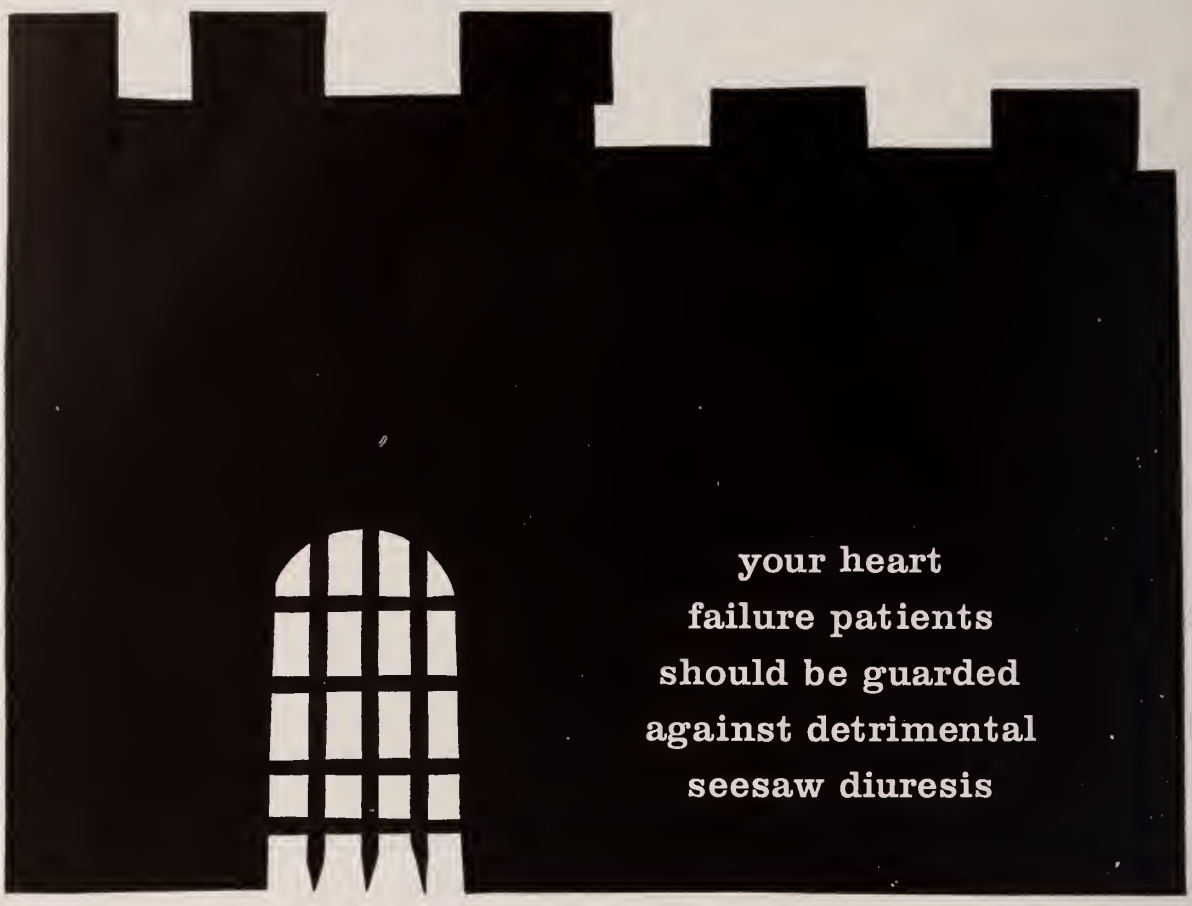

PATIENTS IN FAILURE NEED AN ORGANOMERCURIAL

Limiting dosage to once daily to avoid refractoriness, or omitting alternate days to circumvent gastrointestinal irritation—necessary with some diuretics—results in a seesaw of diuresis with fluid reaccumulation and recurrent strain on the already failing heart.

With the organomercurials, dosage is individualized and administered as needed, to produce sustained, dependable diuresis.

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NEOHYDRIN®

BRAND OF CHLORMERODRIN (18.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

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Sinus Drainage and Aeration

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for greater efficiency

} *plastic, unbreakable squeeze bottle leakproof, delivers a fine mist*

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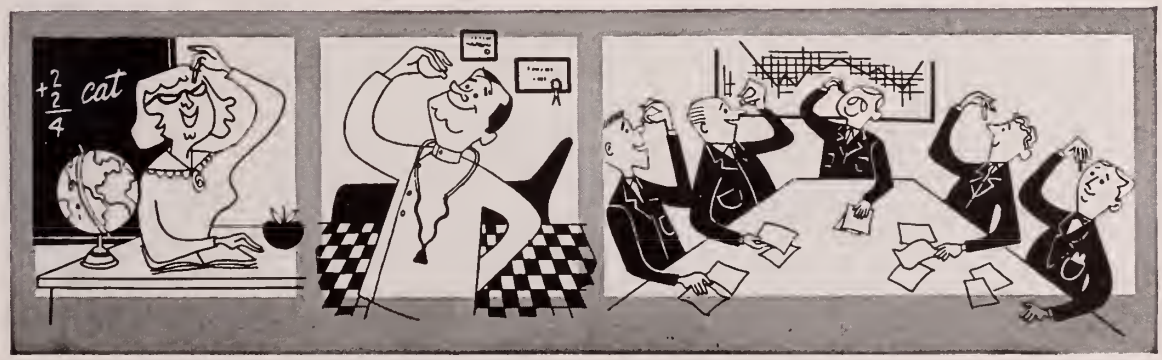

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Dosage is definite and easy: two 2 mg. tablets at bedtime.

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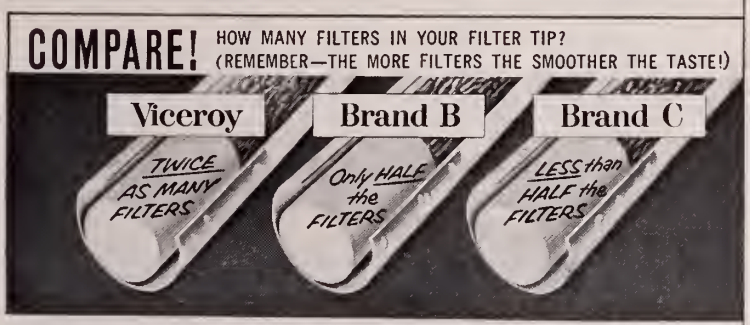

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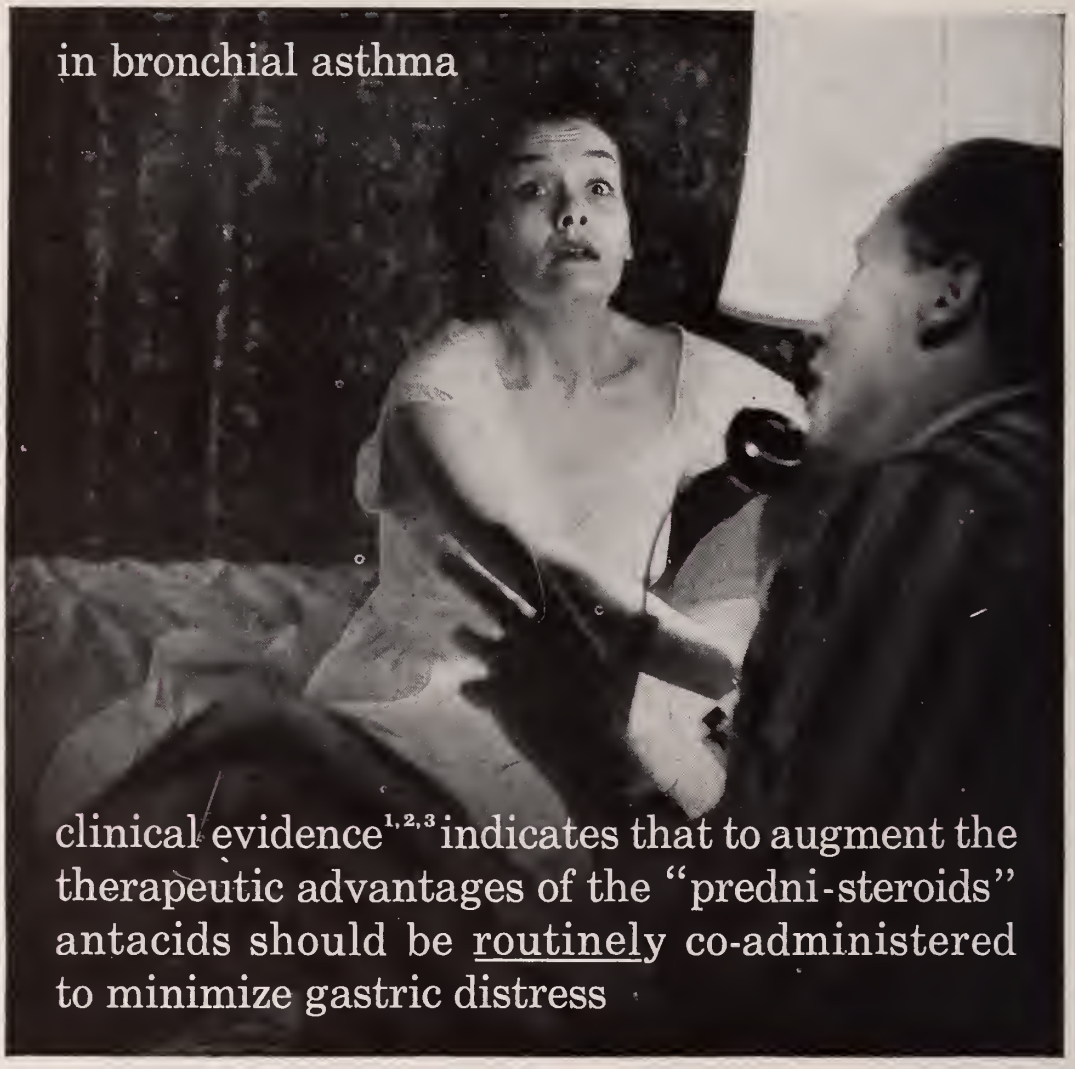
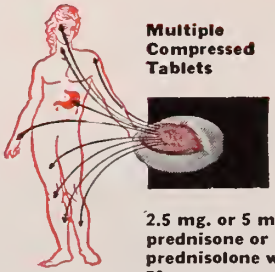


ROUTINE CO-ADMINISTRATION MEANS

'Co-Hydeltra'
(Buffered Prednisolone)



Multiple Compressed Tablets

'Co-Deltra'
(Buffered Prednisone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

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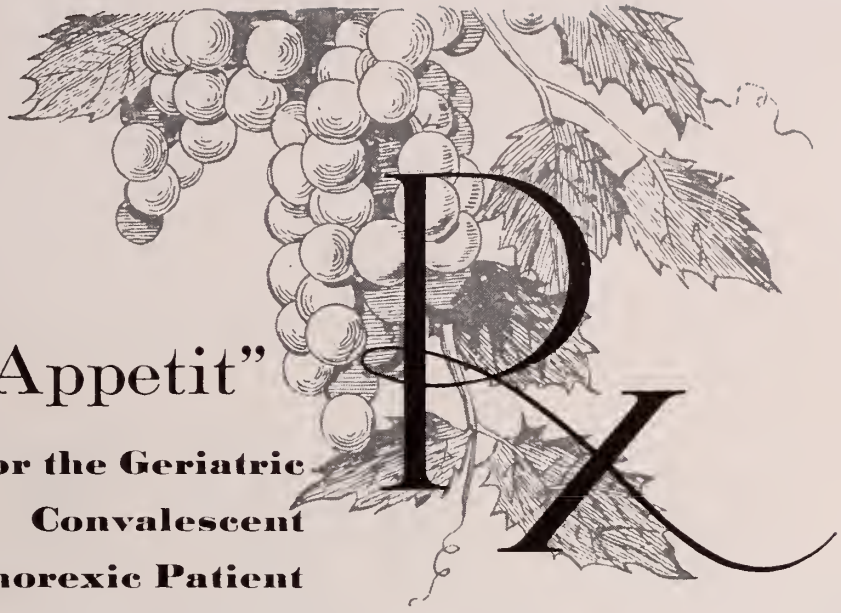

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Notably in the dietetic management of the aged, the convalescent and the post-surgical patient, wine has occupied a foremost position for generations—but it is only of recent times that its distinctive physiologic values and clinical rationale have been systematically studied and evaluated.

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- wine stimulates olfactory acuity—markedly increasing appetite in anorexia
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- a little Port or Sherry at bedtime is a valuable relaxant to the insomniac and may obviate the need for sedative medication

And wine can help brighten the often unappealing character of special or restricted dietaries—a psychological boost of inestimable value to the debilitated and depressed patient.

These and other research data of clinical interest are contained in the brochure "Uses of Wine in Medical Practice." A copy is available to you by writing: Wine Advisory Board, 717 Market Street, San Francisco, California.

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Prednisone + Acetylsalicylic Acid + Aluminum Hydroxide + Ascorbic Acid

Potent corticosteroid anti-inflammatory action complemented by rapi analgesia; doubly protected with antacid and supplemental vitamin C

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"Take it from me, you should be glad you saw him early in the game so he could do some good."

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Ampoules of 0.2 mg. in 1 cc.
Tablets of 0.2 mg.

DOSAGE: Generally, 0.2 to 0.4 mg. I.V. or I.M. immediately following delivery of placenta. Thereafter, 0.2 to 0.4 mg. three or four times daily for two weeks.

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THE WISCONSIN MEDICAL JOURNAL

Volume 55 DECEMBER 1956 Number 12

Puerperal Inversion of the Uterus*

By ELIZABETH ALLEN STEFFEN, M. D.
Racine

PUERPERAL inversion of the uterus is a dangerous complication of pregnancy. This complication occurring in a patient at term carries considerable morbidity and mortality.

The 2 cases we are presenting were both complicated by complete inversion of the uterus. The cause was undetermined. The first case presented the added complication of spontaneous rupture of the uterus during delivery. No causative factor could be found.

Case 1

This 21-year-old, gravida I, para 0, white female was admitted ambulatory to the obstetrical floor on Sept. 21, 1953. Her last menstrual period had been Dec. 10, 1952, and the expected date of confinement was Sept. 17, 1953.

Past History and Prenatal Course:

Familial, medical, and surgical histories were negative; and the prenatal course had been uneventful. All laboratory data were within normal limits.

Course in the Hospital:

The patient was admitted to the labor room at 8:30 a.m. on Sept. 21, 1953, after spontaneous rupture of the membranes at home. Her pains were occurring every three minutes and lasting 35 seconds; blood pressure was 110/70, pulse 80, and temperature normal. Examination revealed vertex presentation, left occipito anterior position with the presenting part at 0 station. The cervix was 70% effaced and 4 cm. dilated. The fetal heart tones were 140 per minute. Rectal examination at 9:30 a.m. showed 5 cm. dilation. The patient was given 100 mg. of Demerol and 10 mg. of vitamin K. At 12 noon the cervix was completely dilated, and the infant's head was on the perineum. The patient was transferred to the delivery room.

At 12:27 p.m. a female infant, birth weight 7 lb., 8 oz., was born spontaneously, with episiotomy done under nitrous oxide and cyclopropane anesthesia. One cubic centimeter of Ergotrate was given intramuscularly. The placenta was not ready to be expelled, and so the episiotomy was repaired. The uterus was boggy during the repair, and there was a continuous ooze of blood. The blood pressure was 130/80, and the pulse was 84. At 1:10 p.m. the placenta delivered spontaneously, and accompanying this was a large gush of blood and clots. The uterus was palpated abdominally and found to be boggy and one fingerbreadth below the umbilicus. One cubic centimeter of Pitocin was given intramuscularly, and one cubic centimeter of Ergotrate was given intravenously. The blood pressure dropped to 80/40; the pulse was 110 and irregular. An infusion of glucose in water was started, and 1 cc. of Methedrine was given into the vein. At 1:40 p.m. Neo-Synephrine, 0.3 cc., was given intravenously, and the blood pressure rose to 106/70. The pulse continued to be thready and rapid. The uterus appeared firm, one fingerbreadth below the umbilicus, but uterine bleeding continued. The skin of the patient was cold and moist, and the anesthetist was unable to elicit any blood pressure. Five cubic centimeters of adrenal cortex was given intravenously.

By 3 p.m. 1,000 cc. of whole blood had been given under pressure, and by 3:30 p.m. an additional 1,000 cc. of blood had been given through multiple sites. The patient's condition improved enough so that sterile vaginal examination could be done. A complete inversion of the uterus was found with the cervix pulled up under the symphysis pubis. The uterus continued to bleed profusely. Palpa-

* From the Department of Obstetrics, St. Luke's Hospital, Racine, Wisconsin.

tion revealed a rent, 6 cm. in length, in the left lateral portion of the corpus. The patient continued in deep shock, the pulse was thready, the blood pressure was not obtainable, and the patient's condition was so poor it was felt further uterine manipulation was not advisable.

She was transferred to surgery by 4:30 p.m. Blood pressure and pulse were not obtainable; but after abdominal incision was made, the aorta was palpated and the pulse found. Anesthesia consisted of cyclopropane and oxygen. Examination of the pelvis showed the uterus to be completely inverted, with the ovaries and the round ligaments pulled into the crater the inversion created. There was about 100 cc. of free blood in the peritoneal cavity that had come from the 6 cm. tear in the left lateral wall of the uterus. There was no active bleeding from the rent. The round ligaments were grasped with ring forceps and the uterus returned to its normal position. Almost immediately the pulse was palpable in the radial artery; the blood pressure rose to 70/40 and then to 140/80, and the pulse counted at 110 per minute. The tear in the uterus was repaired and the abdomen closed. Three additional pints of blood were given during the time the patient was in the operating room, and she left surgery in good condition. Following surgery hemoglobin was 8 gm. and the red blood cell count was 2,800,000.

Puerperium:

Twenty-four hours post partum another unit of blood was given, making a total of eight pints in all since the patient had delivered. Her hemoglobin 48 hours post partum was 10.5 gm., and the erythrocyte count was 3,800,000. She made an uneventful recovery without morbidity.

This patient subsequently delivered and again had a puerperal inversion of the uterus following a normal labor and spontaneous delivery. The uterus was able to be replaced manually to its normal position before shock and extensive blood loss occurred.

Case 2

This 25-year-old, gravida IV, para III, was admitted to the hospital at 2 a.m. on Dec. 26, 1953, with irregular labor pains. Her last menstrual period had been March 23, 1953, and her estimated date of confinement was Dec. 30, 1953.

Past History and Prenatal Course:

There was no history of surgery or serious medical disease. Three previous pregnancies had been normal and without complications.

Course in the Hospital:

Examination revealed a blood pressure of 150/90, pulse of 82, and normal temperature. Abdominal examination showed vertex presentation with the infant in left occipito anterior position with fetal heart tones 140 per minute. Rectal examination showed the station to be –3 and the cervix 70% effaced with 2 cm. dilation.

Desultory labor continued until noon on December 26. At that time 2 cc. of Pitocin was given in the form of a nasal pack without result. At 10 p.m. the pains began to be regular, and the patient started in active labor, station –2, the cervix 2 to 3 cm. dilated. The fetal heart tones were 144 per minute. At 8 a.m. on December 27, 50 mg. of Demerol was given for pain, and the membranes ruptured spontaneously. The cervix was 4 to 5 cm. dilated and the station of the head at 0. At 1:15 p.m. a female infant, birth weight 7 lb., 9 oz., delivered spontaneously. No episiotomy was done, and there were no lacerations. Blood loss appeared brisk and greater than normal. It was estimated to be 300 cc. At 1:35 p.m. the placenta was delivered by Credé maneuver. The uterus appeared firm and was one fingerbreadth below the umbilicus.

At 2:30 p.m. the patient complained of backache, and several large clots were expelled when the fundus was compressed. The blood pressure dropped to 70/50, and the pulse became thready and weak. One unit of blood was given. Following the administration of the blood, the hemoglobin was 12 gm., and the red blood cell count 3,500,000; the blood pressure rose to 100/80 with a regular pulse. In the next few hours the uterus intermittently relaxed, and clots were expelled by compressing the fundus. At 7 p.m. there was a large amount of vaginal bleeding, and the patient went into shock. The blood pressure was 80/50 and the pulse 112. The uterus was two fingerbreadths below the umbilicus and firm. A second blood transfusion of 500 cc. was given, and at 8 p.m. the patient was taken to surgery.

Examination under general anesthesia revealed complete inversion of the uterus with the uterus in the vagina. Under cyclopropane anesthesia the uterus was gently manipu-

lated through the cervix and replaced. Within 10 minutes the blood pressure and pulse were stable and the patient's color good. The puerperium was uneventful.

Comment

Available literature varies in figures given on incidence of rupture of the pregnant uterus. Most authors report the incidence to be 1:1,800 to 1:3,000 deliveries. Spontaneous rupture without a causative factor is uncommon. Most cases are associated with multiparity, previous corpus scars, cervical or myomectomy scars, large infants, or abnormal implantation of the placenta. In the case presented, there was no previous history of operative procedure or abnormality of presentation to suggest a complication of such magnitude.

In large series of cases presented by Bell[1] and Henderson[2] in which puerperal inversion occurred, the presenting symptoms were excessive blood loss and shock. A consistent symptom is shock out of proportion to the amount of blood that has been lost. This has been so universally reported that, when confronted with it, one must think of acute inversion. Authors are in agreement that immediate recognition and treatment offers the best chance for survival of the patient. Most deaths occur within a few hours and are accompanied by primary shock or neurogenic shock. Blood and supportive treatment often are not enough. The stretching of the uterus and its nerve plexuses in the broad ligaments and ovaries may make replacement of the uterus mandatory for recovery of the patient. In both cases presented the patients received adequate blood replacement, but recovery from shock promptly followed replacement of the uterus to normal position.

Summary

1. In neither case presented was cupping of the uterus palpated nor was there disappearance of a suprapubic mass. In these 2 cases we were not able to make diagnosis upon abdominal palpation.

2. In neither case was there any mismanagement of the third stage of labor.

3. In the 1 case in which spontaneous rupture was found coexisting with uterine inversion, there was no causative factor determined. The extensive blood loss was from the inversion.

4. In both cases presented, recovery from shock promptly following replacement of the uterus to its normal position.

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211 Ninth Street.

I wish to thank Walter C. Roth, M. D., for his help in supplying data for this paper.

REFERENCES

1. Bell, J. E., Jr., Wilson, G. F., and Wilson, L. A.: Puerperal inversion of uterus, Am J. Obst. & Gynec. 66:767–780 (Oct.) 1953.
2. Henderson, H., and Alles, R. W.: Puerperal inversion of uterus, Am. J. Obst. & Gynec. 56:133–142 (July) 1948
3. Brierton, J. F.: Rupture of pregnant uterus, Am. J. Obst. & Gynec. 59:113–124 (Jan.) 1950.
4. Eastman, N. J.: Williams Obstetrics, ed. 10, New York, Appleton-Century-Crofts, Inc., 1950, p. 923.
5. Members of the staff of the Pennsylvania Hospital; Lull, C. B., and Kimbrough, R. A., editors: Clinical Obstetrics, Philadelphia, London, and Montreal, J. B. Lippincott Company, 1953, p. 354.

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Problems in Intestinal Obstruction in the Neonatal Period*

By DONALD S. THATCHER, M. S. (Surg.), M. D., F. A. C. S.
Milwaukee

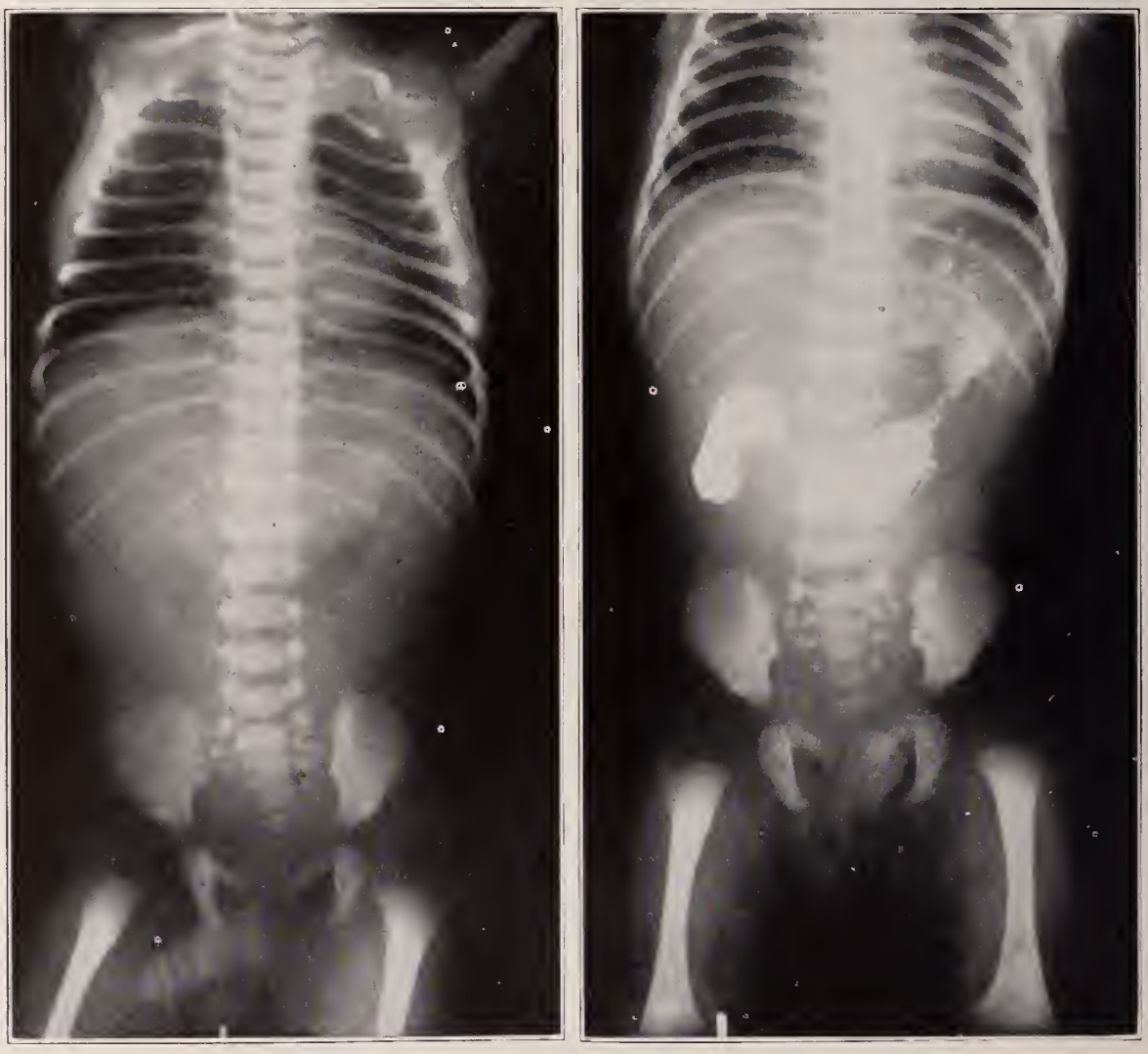

Fig. 1—Duodenal atresia below the level of the ampulla of Vater.

INTESTINAL obstructions which occur in the neonatal period require prompt and reasonably accurate diagnosis and rapid and effective surgical treatment if the infant is to survive. The problems involved in the surgical treatment of 4 cases of congenital obstruction of the small bowel and 3 cases of obstruction due to imperforate anus will be discussed.

* From the Surgical Services of Milwaukee Hospital and Milwaukee Children's Hospital. Presented at the meeting of The Wisconsin Surgical Society, May 2, 1956.

SMALL BOWEL OBSTRUCTIONS

The first case (fig. 1) is that of a 3-day-old male infant with symptoms of vomiting of all feedings since birth, absence of any normal passage of stool, and presence of bile in the vomitus.

Preoperative diagnosis was congenital duodenal atresia below the level of the ampulla of Vater. At operation a duodenojejunostomy was performed between the dilated second portion of the duodenum and the proximal jejunum. The child made an un-

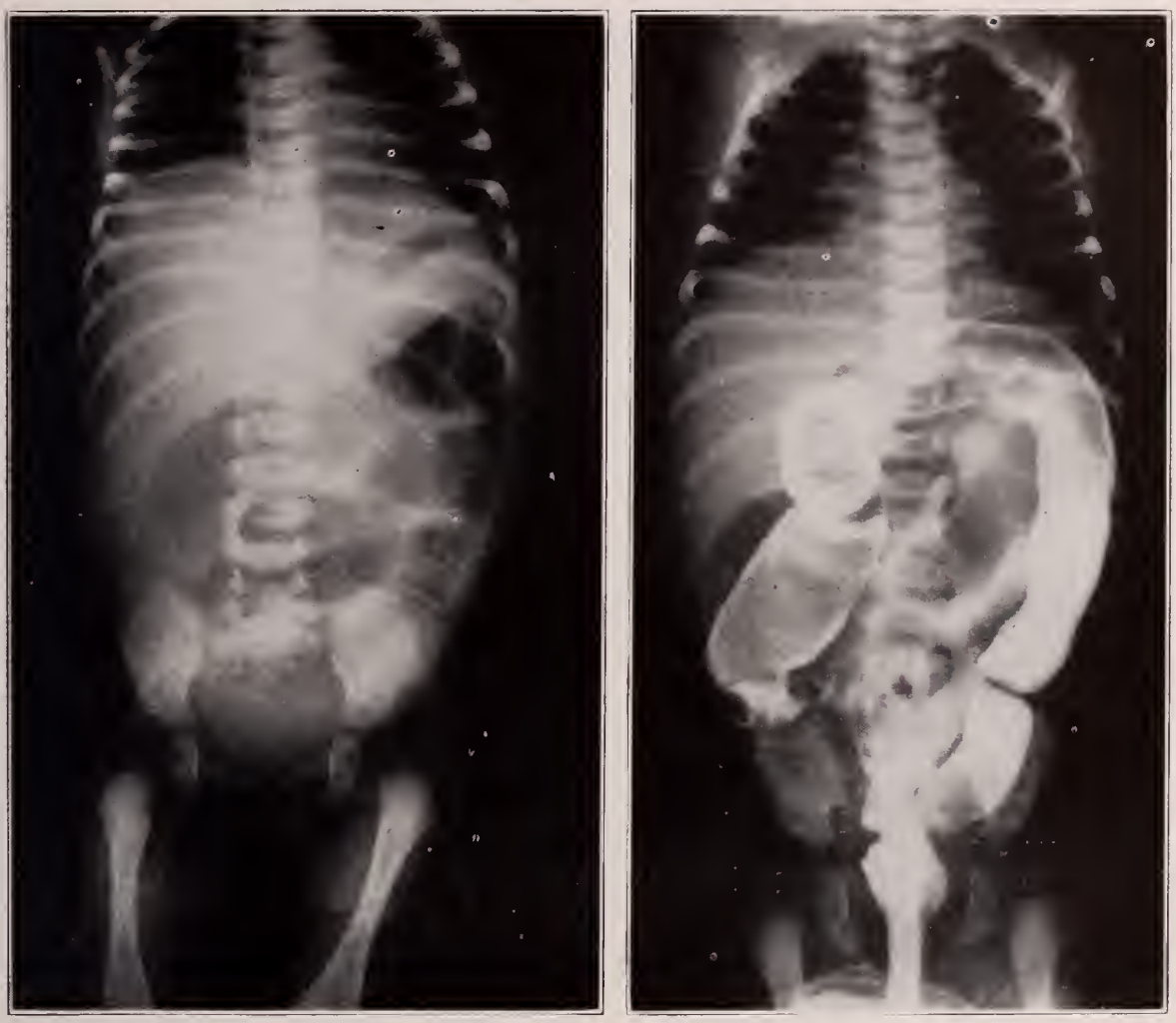

Fig. 2—Obstruction of distal ileum due to fibrocystic disease of pancreas.

eventful recovery and has been followed for a period of four years with ample evidence of normal growth and development and no evidence of further anomalies.

* * *

The second infant (fig. 2) was a 9-day-old female with symptoms of vomiting of all feedings within three to fifteen minutes after they were given. There was no spontaneous passage of stool. The vomitus contained bile, and there was a weight loss of 1 lb., 2½ oz. in the nine days after birth. The child was severely dehydrated and showed evidence of marked wasting. The rectum contained yellow stool, and the abdomen was distended and tight, with visible peristaltic waves.

Preoperative diagnosis was intestinal obstruction, small bowel type, probably atresia of the ileum. At operation an enormously dilated jejunum and proximal ileum was found. The distal ileum was of normal size and was patent, and gas and intestinal content could be milked through the distal ileum into the colon, which was filled with a solid column of feces. Since there was no evidence of intrinsic obstruction and since there was serious question of whether or not the innervation of the colon was adequate, it was not felt that ileotransverse colostomy or other anastomosis was indicated. The abdomen was closed without further surgical procedure. The child was treated with supportive therapy, indwelling gastric suction, oil enemas, and oil placed down the suction tube; but in spite of all measures, the child expired on the sixth postoperative day. Autopsy revealed fibrocystic disease of the pancreas, atelectasis, and ulceration and hemorrhage

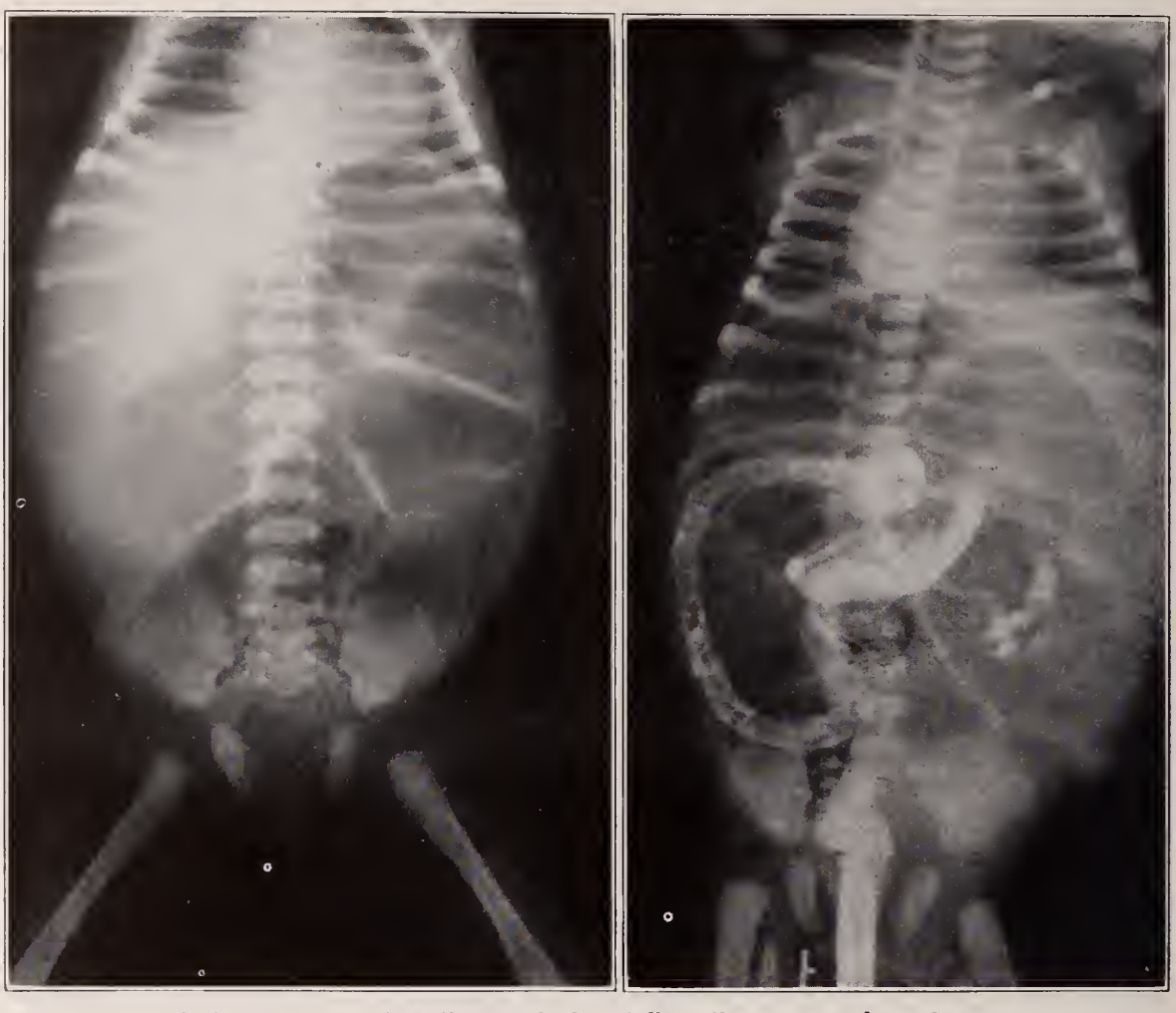

Fig. 3—Stenosis of proximal ileum, volvulus of distal ileum, and undescended cecum.

of the gastrointestinal tract secondary to the fibrocystic disease of the pancreas.

* * *

The third case (fig. 3) is that of a 12-hour-old infant girl in whom immediate abdominal distention and vomiting developed after delivery. Preoperative diagnosis of intestinal obstruction, small bowel type, probably due to atresia, was made. At operation a complete stenosis of the proximal ileum was found. There was also a complete volvulus of the distal ileum upon a defective mesentery and a hiatus hernia in the mesentery of the proximal ileum. There was an undescended cecum, and the ascending colon lay transversely in the upper abdomen. Resection of the stenosed portion of the ileum was done and a side-to-side anastomosis completed between the loops of ileum. Following this operation the infant passed small amounts of fecal material and gas, but on the eighth postoperative day it was obvious that the anastomosis was no longer functioning and that obstruction had recurred. The child was operated upon a second time, and a second anastomosis was made between ileum and transverse colon. There was no improvement following this operation, and the child expired on the fourth postoperative day. Autopsy revealed that both anastomoses were wide open but were completely occluded by thick, black, puttylike material. There was no evidence of fibrocystic disease of the pancreas. The mechanical plugging effect of the meconium must have been due to inspissation of the meconium trapped above the area of stenosis in the ileum; the meconium must have become inspissated to such a state that it could no longer be propelled by normal peristalsis in the bowel. This problem was further aggravated by the

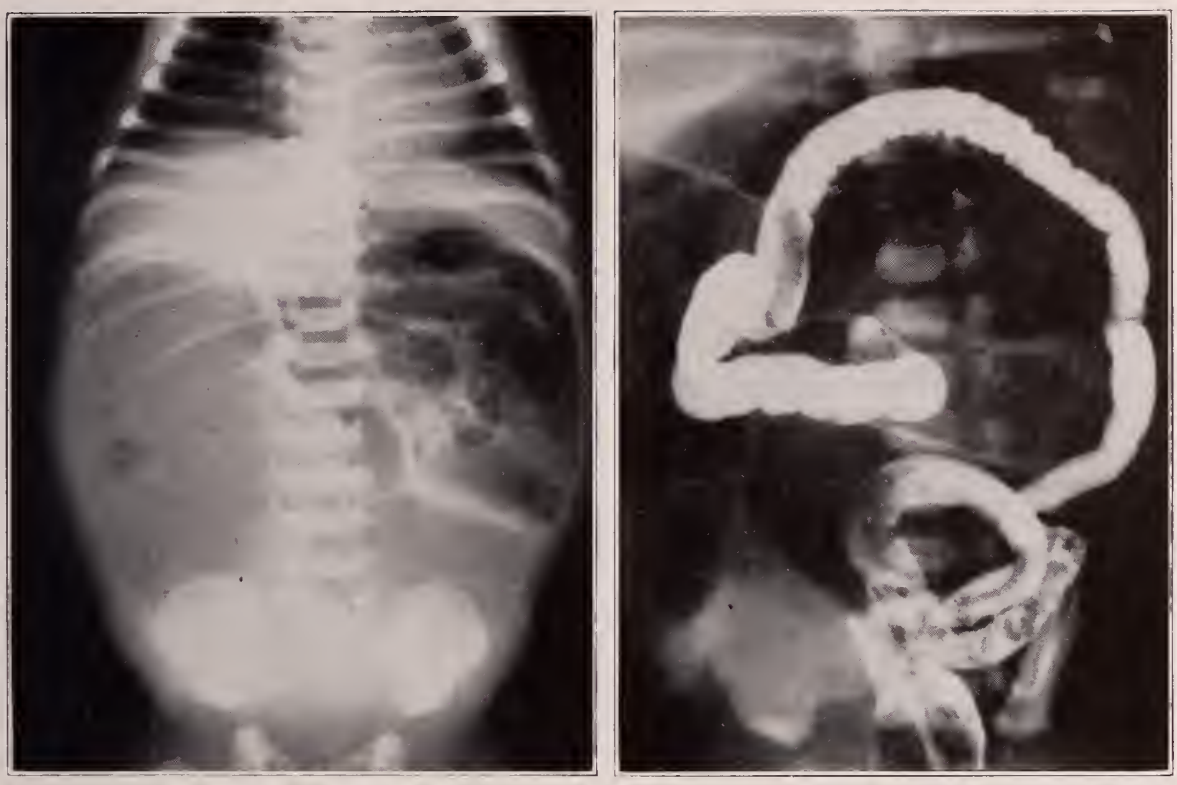

Fig. 4—True midgut volvulus, multiple areas of atresia of ileum, and stenosis of jejunum.

fact that the patient was not able to take any fluids by mouth for the first few postoperative days. Death was due to mechanical ileus resulting from meconium impaction of the intestinal anastomoses.

* * *

The fourth case (fig. 4) is that of a male infant, 14 hours old, with abdominal distention, vomiting, failure of passage of normal stool, and x-ray evidence of true midgut volvulus. At operation a true midgut volvulus was found with an incompletely rotated and incompletely descended cecum, a congenital band obstructing the third portion of the duodenum, three areas of complete atresia of the terminal ileum, and failure of development of mesentery of the terminal ileum and ascending colon. The entire small bowel mesentery was attached to one small pedicle just below the superior mesenteric vessels, and on this pedicle the entire mesentery and small bowel had rotated in a counterclockwise manner, almost 360 degrees. There was a stenotic membrane present at the level of the junction of jejunum and ileum, and there were three blind segments of distal ileum. The infant's condition would not permit the prolonged surgical procedure necessary to accomplish multiple resection and anastomoses of four separate segments of ileum; therefore, after correction of the midgut volvulus, the blind ileal segments and ascending colon were resected, and end-to-end anastomosis was accomplished between the dilated proximal jejunum and the transverse colon by a Hofmeister–Polya type technique. The sacrifice of this much distal small bowel and ascending colon in a newborn infant would lead one to anticipate a stormy postoperative course, and such was the case. However, the infant finally began to retain feedings and gradually began to hold his weight and then showed progressive weight gain until the time of discharge from the hospital.

In these 4 cases of primary small bowel obstruction the simple type of duodenal atresia treated by duodenojejunostomy is in definite contrast to the multiple anomalies found in the case of true midgut volvulus. The other 2 cases represent one of the most difficult problems to handle in the neonatal period; namely, intrinsic intraluminal ob-

TABLE 1—*Small Bowel Obstructions*

Type of Bowel Obstruction and Age of Infant	Operation	Result	Associated Anomalies
Duodenal atresia below ampulla of Vater 3 days	Duodenojejunostomy	Living and well	None
Low small bowel 9 days	Laparotomy only	Expired	Autopsy— 1. Fibrocystic disease 2. Atelectasis 3. Ulceration and hemorrhage in gastrointestinal tract secondary to fibrocystic disease 4. Meconium ileus secondary to fibrocystic disease
Complete stenosis of proximal ileum. Volvulus of distal ileum. Hiatus hernia in mesenteric defect of proximal ileum. Undescended cecum. 12 hours	1. Resection and anastomosis of stenotic ileum 2. Reduction of volvulus 3. Reoperation and ileotransverse colostomy	Expired	Autopsy— Mechanical obstruction of both anastomotic stomata by inspissated meconium. Not true fibrocystic disease.
Midgut volvulus 14 hours	Correction of volvulus Resection of ileum and ascending colon and end-to-end anastomosis	Living and well	3 areas of complete atresia, terminal ileum. Defective mesentery of ascending colon. Stenosis of jejunum.

struction from inspissated meconium, either with or without an associated true fibrocystic disease of the pancreas, or so-called mucoviscidosis. All patients were operated upon through right upper transverse abdominal incisions. Anastomoses were completed by the two-layer technique with an inner row of continuous 5–0 atraumatic intestinal catgut and an outer layer of continuous 4–0 or 5–0 atraumatic silk suture.

IMPERFORATE ANUS

Fig. 5—Imperforate anus with rectovaginal fistula. Atresia of esophagus.

These 3 cases of imperforate anus present different problems in surgical management. The first patient (fig. 5) was a newborn female infant with abdominal distention, absence of passage of any stool or meconium, and obvious imperforate anus. This infant was premature, and it was felt that repair by perineoproctoplasty offered the greatest possibility of success without the shock to the infant of an intra-abdominal procedure. At operation a rectovaginal fistula was identified. The fistula was resected, and the blind rectal pouch was brought down to the perineum satisfactorily without tension. This child did well until the second postoperative day, when it became apparent that there was an additional anomaly in the upper intestinal tract; x-rays revealed an esophageal atresia with tracheo-esophageal fistula, type III. Surgical correction of this anomaly was accomplished, but the child was unable to tolerate a second surgical procedure within two days and expired.

* * *

The second case (fig. 6) is that of a 48-hour-old male infant admitted to Children's Hospital after an unsuccessful attempt at primary perineoproctoplasty. Immediately after delivery the infant also evidenced agenesis of the oblique abdominal muscles, a penile type of hypospadias, bilateral abdominal cryptorchidism, and a stab wound lateral to the anal dimple in the perineum. Pressure over the perineum caused the expression of a small amount of gas through the stab wound; however, no meconium or feces were evident in the wound. In the face of the stab wound in the perineum it was felt that the perineal and the perirectal tissues were at least potentially infected; and a primary plan of treatment by staged procedures with preliminary colostomy, secondary perineoproctoplasty, and ultimate closure of the colostomy was outlined. Transverse colostomy of the simple loop type was carried out upon the patient's admission to this hospital in August, 1952. In March, 1953, a perineoproctoplasty was accomplished. On the nineteenth postoperative day there was some disruption of the perineal wound, and a secondary repair was necessary. One-half of the circumference of

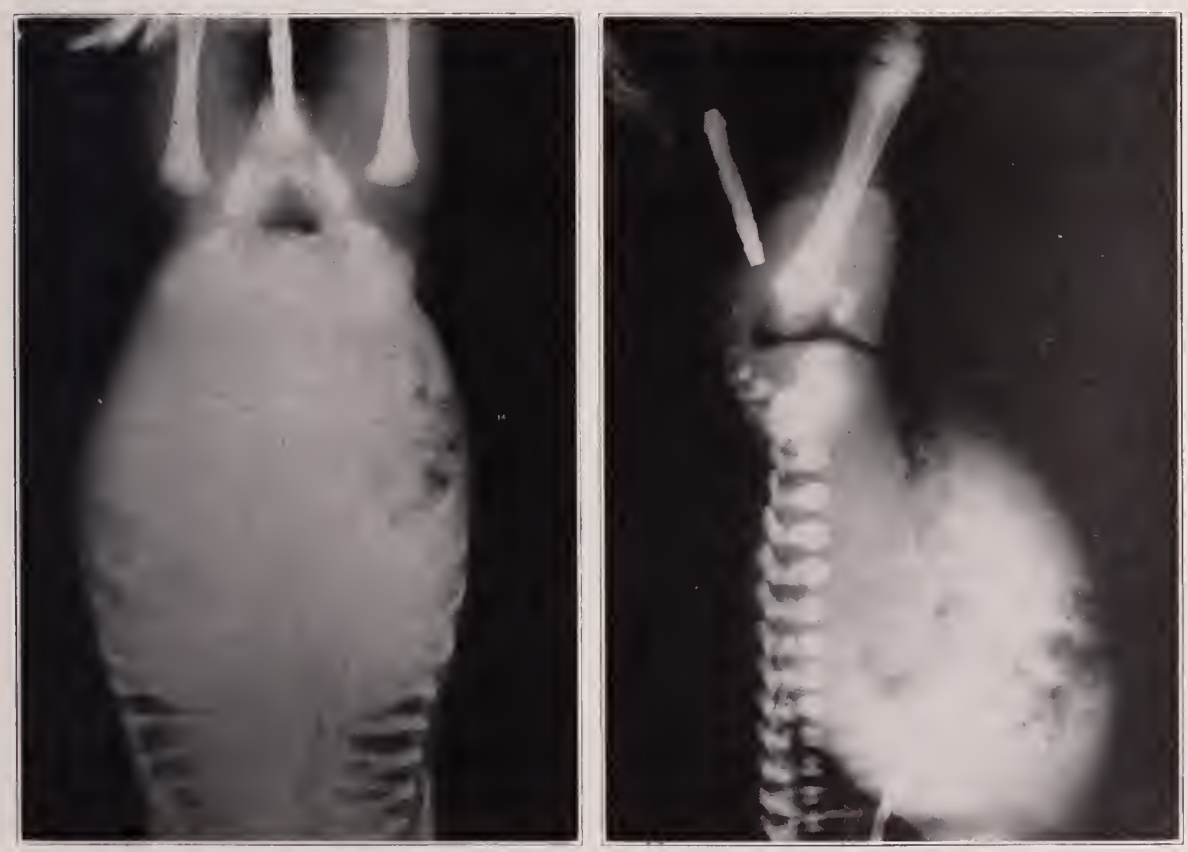

Fig. 6—Imperforate anus, type II. Multiple associated anomalies of genitourinary tract.

Fig. 7—Hydro-ureter due to chronic obstructive ureteropyelonephritis.

the rectum, which had retracted from its attachment to the skin edge, was reattached. In September, 1953, the transverse loop colostomy was closed. In October a left nephro-ureterectomy was carried out because of the presence of an enormous hydro-ureter and hydronephrosis (fig. 7). The pathological diagnosis was chronic obstructive ureteropyelonephritis. In February, 1956, repair of the penile type of hypospadias was carried out with primary closure of the hypospadias, meatotomy, and a diversionary perineal urethrotomy. Recovery from this procedure was uneventful. The problem of bilateral cryptorchidism remains to be dealt with in the future. If it is possible to identify testes and accomplish placement of the testicle in the scrotal sac on one or the other side, this boy's multiple congenital anomalies will have been successfully corrected.

The third case (fig. 8) is that of a 1-day-old female infant with imperforate anus, type III; rectovaginal fistula; and congenital heart disease. This child was operated upon by the primary abdominoperineal technique. A large fistula between the blind rectal pouch and the posterior fornix of the vagina was resected, and the blind rectal pouch was easily brought down to the perineum and sutured into position without tension at the perineal skin margin. This child's postoperative course has been complicated by recurring cyanosis and retardation of normal growth and development due to major cardiac anomaly, which is thought to be of the Eisenmenger type.

All 3 cases of imperforate anus presented problems of multiple anomalies, involving the genitourinary and cardiovascular systems, as well as the upper gastrointestinal system. Gross[1] emphasizes the fact that 71% of all cases of imperforate anus have an associated fistula, and that in 39% of cases there are other congenital anomalies which very often are directly responsible for mortality. These are most commonly congenital heart disease, atresia of the intestinal tract, and atresia of the esophagus. Santulli[2] states that 34% of cases show associated congenital anomalies. Moore and Lawrence[3] quote an incidence of additional congenital anomalies of 72% and state that the anomalies occur most frequently in the urinary tract. Bacon and Sherman[4] also call attention to the high incidence of associated anomalies of the other body systems occurring in conjunction with malformation of the anus and rectum. This is in distinct contrast to the relatively low incidence of other associated anomalies in the presence of stenosis or atresia occurring

TABLE 2—*Imperforate Anus*

Type of Imperforate Anus and Age of Infant	Operation	Result	Associated Anomalies
Type III with rectovaginal fistula. Premature	Perineoproctoplasty with resection of fistula	Expired after second operation	Esophageal atresia—Type III—repaired 2 days after perineoproctoplasty
Type II with perineal stab wound. 48 hours	1. Primary colostomy 2. Perineoproctoplasty 3. Closure of colostomy 4. Nephro-ureterectomy 5. Hypospadias repair	Living and well	Penile hypospadias Bilateral cryptorchidism Chronic obstructive ureteropyelone . phritis
Type III with rectovaginal fistula. 24 hours	Abdominoperineal repair. One-stage resection of fistula	Living and well	Congenital heart disease with cyanosis

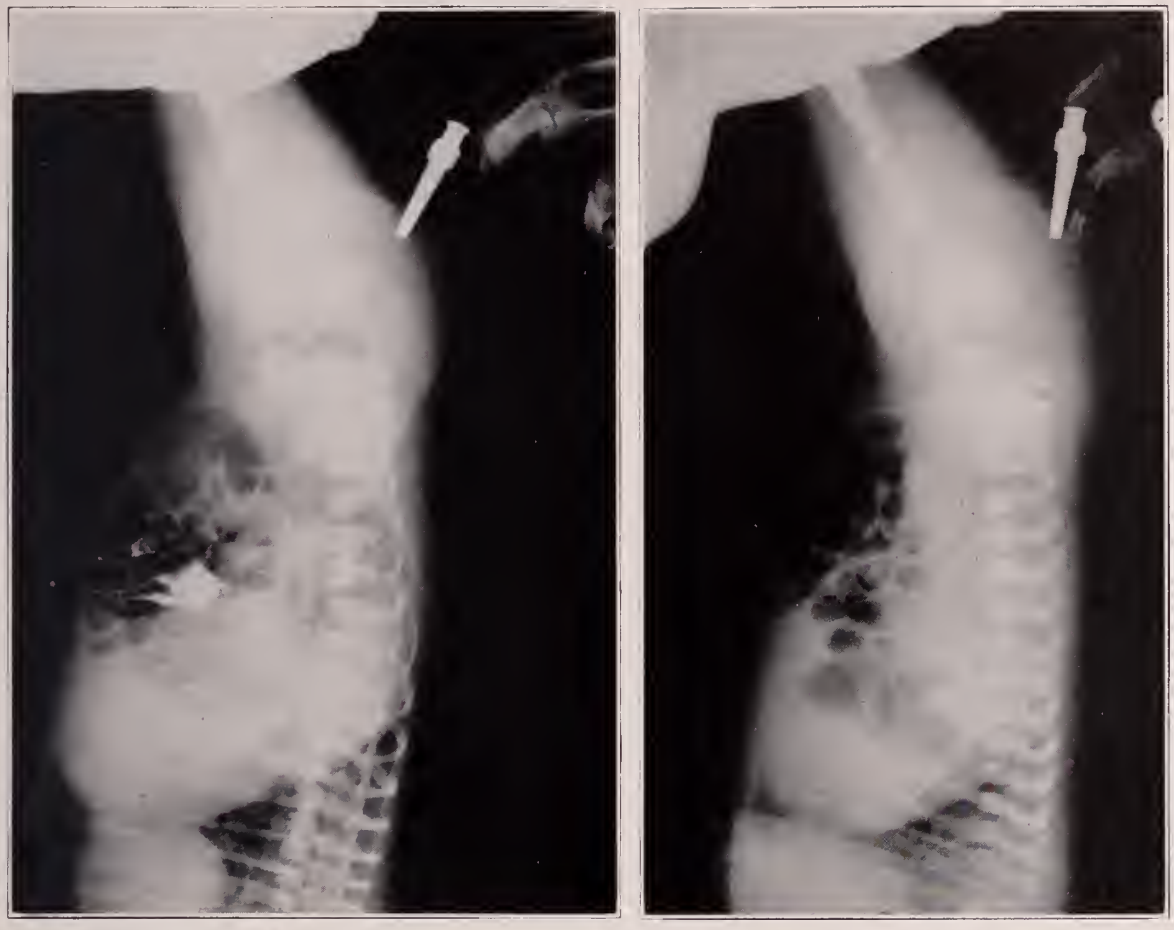

Fig. 8—Imperforate anus, type III, with rectovaginal fistula and cyanotic congenital heart disease.

high in the intestinal tract;[5] esophagus; duodenum; or, rarely, the stomach.[6]

Summary

Four types of neonatal intestinal obstructions involving lesions in the small bowel are presented. Two of these patients were treated with successful result and recovery and two expired. Three cases of malformation of the anus and rectum with associated anomalies are presented, and the surgical treatment by three different techniques is described. The high incidence of associated anomalies, not only in the form of multiple anomalies of the intestinal tract, but also as anomalies of other organ systems such as the genitourinary and cardiovascular systems should constantly be borne in mind by the surgeon. This is emphasized by the fact that in 2 of the 4 cases of small bowel lesion and in all 3 of the cases of imperforate anus, there were associated anomalies of other portions of the gastrointestinal system or of other organ systems of the body.

Conclusion

The management of neonatal intestinal obstructions requires early diagnosis and prompt surgical correction with adequate supportive therapy with parenteral fluid and blood. The surgeon must conduct an adequate and careful search for additional anomalies which may represent threats to the life of the infant. Enthusiasm for extensive surgical correction of multiple anomalies should not outweigh good surgical judgment, which may indicate a minimum of manipulation in the immediate neonatal period or in the face of prematurity, even though a multiple-staged procedure may not appear to be as desirable.

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REFERENCES

1. Gross, R. E.: The Surgery of Infancy and Childhood; Its Principles and Techniques, Philadelphia, W. B. Saunders Company, 1953, pp. 75–126, 150–204, 348–369.
2. Santulli, T. V.: Treatment of imperforate anus and associated fistulas, Surg., Gynec. & Obst. 95: 601–614 (Nov.) 1952.
3. Moore, T. C., and Lawrence, E. A: Congenital malformations of rectum and anus; associated anomalies encountered in series of 120 cases, Surg., Gynec. & Obst. 95:281–288 (Sept.) 1952.
4. Bacon, H. E., and Sherman, L. F.: Surgical management of congenital malformations of anus and rectum; report of 111 cases, A.M.A. Arch. Surg. 64:331–344 (March) 1952.
5. Moore, T. C., and Stokes, G. E.: Congenital stenosis and atresia of small intestine, Surg., Gynec. & Obst. 97:719–730 (Dec.) 1953.
6. Benson, C. D., and Coury, J. J.: Congenital intrinsic obstruction of stomach and duodenum in newborn, A.M.A. Arch. Surg. 62:856–866 (June) 1951.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1956, the March of Medicine began its eleventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 35 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	4:15 p.m.
WHSA	Brule	Wednesday	9:15 a.m.
WHKW	Chilton	Wednesday	9:15 a.m.
WHWC	Colfax	Wednesday	9:15 a.m.
WHAD	Delafield	Wednesday	9:15 a.m.
WEAU	Eau Claire	Saturday	11:45 a.m.
KFIZ	Fond du Lac	Friday	6:45 p.m.
WBAY	Green Bay	Saturday	5:15 p.m.
WHHI	Highland	Wednesday	9:15 a.m.
WLIP	Kenosha	Saturday	9:45 a.m.
WKBH	La Crosse	Saturday	10:45 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Wednesday	9:15 a.m.
WIBA	Madison	Saturday	11:00 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Saturday	8:15 p.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	10:00 a.m.
WEKZ	Monroe	Friday	1:15 p.m.
WPFP	Park Falls	Saturday	4:30 p.m.
WSWW	Platteville	Saturday	4:15 p.m.
WPLY	Plymouth	Saturday	8:30 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:15 p.m.
WRDB	Reedsburg	Tuesday	9:30 a.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WRCO	Richland Center	Saturday	5:15 p.m.
WTCH	Shawano	Sunday	6:45 p.m.
WDOR	Sturgeon Bay	Thursday	10:45 a.m.
WTTN	Watertown	Tuesday	11:30 a.m.
WSAU	Wausau	Saturday	8:45 a.m.
WBKV	West Bend	Saturday	11:15 a.m.

Fibrin Emboli of the Lungs With Afibrinogenemia After Cesarean Section

Without the Presence of Amniotic Epithelial Squames

By E. S. OLSON, M. D.
Racine

Report of a Fatal Case

THIS 21-year-old patient was admitted for her third cesarean section and tubal ligation. She was considered to be in excellent condition. There were no remarkable incidents during surgery. The tubes were ligated according to the Pomeroy technique. The blood pressure gradually dropped from 124/60 to 84/70 in 18 hours, and the pulse increased to 130. The patient was explored, and a slipped suture on a vessel on the fallopian tube was found. The vessel was again ligated. There was no pulse or blood pressure obtainable during surgery.

Following surgery the blood pressure was 74/40, and one-half hour later it was 0/0 and remained so for one hour. After this it varied between 0/0 and 132/80.

The patient was again explored 24 hours after her cesarean section. There was considerable bleeding into the subcutaneous and retroperitoneal tissues, with a moderate amount of blood present in the peritoneal space. A hysterectomy was done in an attempt to control the hemorrhage. The patient expired almost immediately in spite of supportive therapy.

One fibrinogen determination was done before the second operation. It was .096%. Two grams of fibrinogen was given at that time.

The patient was given 24 transfusions along with saline and Levophed, as well as Cortef for supportive therapy.

Postmortem Findings

There was considerable oozing from the subcutaneous tissue when it was incised. The lungs were completely atelectatic. The fascial sheaths, retroperitoneal tissue, and mesentery were infiltrated with blood. There was a large amount of free blood in the peritoneal space. The heart showed no evidence of dilatation.

The remainder of the organs were not remarkable, except for congestion.

Microscopic examination showed fibrin emboli in the lungs. There were no epithelial cells from the amniotic fluid present in the lungs. Ciliated epithelium from the tubes was found in the lungs.

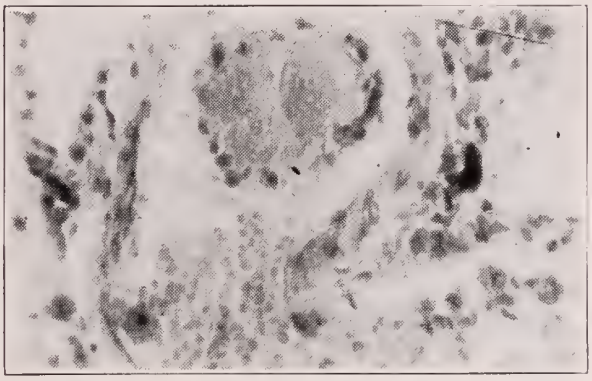

Fig. 1—Fibrin embolus in a pulmonary vessel.

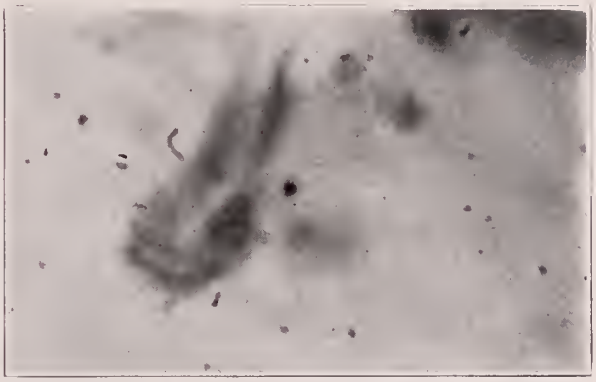

Fig. 2—Ciliated epithelium from the fallopian tube in a pulmonary vessel.

Discussion

Factors considered in the discussion will include the formation of fibrin emboli, their fleeting character, and their clinical manifestations. We will review conditions that lead to an unstable clot and incoagulable blood. The rationale of prophylactic and active treatment will also be reviewed. Use

of Levophed in these cases is of some interest and will be contrasted to the use of Adrenalin, which encourages an unstable clot.

Plasmin was first described by Dastre in 1893.[1] He called it fibrinolysin. Plasmin is present in the inactive stage in the globulin fraction of the blood. It is called plasminogen. Plasminogen is maintained in the inactive stage by antiplasmin. This is present in the albumin fraction. Virchow (1871) noted that the blood in the capillaries never clotted.[2] This may be due to plasmin in the capillaries.

Plasmin is thought to be present in the uterus.[2] It is present in many patients after surgery. It occurs even after minor surgical procedures.[3] Plasmin activity may be reduced if preoperative medication is omitted.[3] This is explained by the fear and apprehension of impending surgery. Preoperative medication alone will cause fibrinolysin.[3]

Plasmin is associated with some cases of trauma.[3] It may be present following hemorrhage and burns. It is not associated with peripheral vascular collapse alone. It has been described after sudden death[3] and exercise.[4] The administration of Adrenalin constantly activates plasminogen in humans.[5] Levophed injected into dogs showed no activation of plasminogen.[6]

Plasmin is present in cases in which there is an alarm reaction. It was seen in civilians during the air raids.[3] It developed in the absence of the liver, pancreas, spleen, or suprarenal cortex.[5] Plasmin becomes absorbed and concentrated in a blood clot.[5]

Plasminogen is activated into plasmin by chloroform, ether, or thymol. It can again be inactivated by the antiplasmin in the albumin fraction of the blood.[5]

Plasmin reduces prothrombin, fibrinogen, fibrin, and also possibly prothrombin accelerators. It will digest casein and gelatin.[7]

Streptokinase activates plasminogen.[5] This is the basis for the use of this material clinically (Varidase).

Thromboplastin intravenously causes an anaphylactoid reaction. There is failure of the peripheral circulation, failure of respirations, and cessation of the heart beat. Fibrin emboli are present in the pulmonary vessels. They will disappear within one day. Afibrinogenemia results with hemorrhage. Cor pulmonale develops with a large liver and pooling of the blood in the splanchnic vessels.[8]

Amniotic fluid and decidual and placental tissues are good sources of thromboplastin.[9] Trauma to the placenta of a rabbit will cause fibrin emboli.[8] In severe cases of abruptio placentae, there are similar findings in the human. This is often attributed to toxemia or renal failure. Fibrin emboli occur in some cases of eclampsia.

Amniotic fluid can be used for the prothrombin determination. This fluid does not contain fibrinogen, thrombin, prothrombin, or plasmin.[10] We believe the thromboplastin content is more important than the intravascular cellular debris in some cases. This is true in the case we have presented.

Amniotic emboli were first described in 1941.[5] They can occur whenever the sinuses of the uterus are opened, *e.g.*, when there is rupture of the uterus, cesarean section, or presence of a tear.

Amniotic emboli are likely to develop in multiparas beyond the expected confinement date with a large fetus.[11] One case was observed in a primipara.[12] The use of pituitary extracts in these cases may be a factor. It would increase intrauterine pressure and favor amniotic fluid absorption.[9,10]

Death can occur in minutes or hours. It occurred at the time of surgery in one case of cesarean section. The placental site was incised.[13] In one case a catheter could be passed from the region of the tear to the larger veins in the broad ligament.[14] Two other patients died 10 minutes[15] and 20 minutes[11] after admission.

Platelets are considered to be important by some. Hemorrhage is said not to occur unless they are decreased.[16] A platelet extract (sertonin) will cause vasospasm and hypertension.[8] The platelets are enmeshed in the fibrin of the clots and could aggravate the cor pulmonale that is present in fibrin emboli. The spasm would also interfere with circulation.

The diagnosis of afibrinogenemia, which is associated with fibrin emboli, can be established by taking blood aseptically and incubating it at 37 C. for 30 minutes. A clot will not form in afibrinogenemia, or a poor clot may form. If the clot dissolves after it is incubated another 60 minutes at 37 C., this demonstrates the presence of plasmin. Afibrinogenemia can be confirmed by chemical determination. The normal level of fibrinogen in the blood is 300 to 500 mg.%. The critical level is from 100 to 150 mg.%.

Treatment can be divided into prophylaxis and active treatment.

Prophylactic measures include the avoidance of pituitary extracts in multiparas who are progressing satisfactorily.[9,10] Every attempt should be made to avoid the absorption of thromboplastin as much as possible during cesarean section. Trauma to the placenta can be dangerous.[8,13] Thromboplastin can be absorbed from the decidua and amniotic fluid. Rupture of the uterus should be avoided for similar reasons, and afibrinogenemia should be suspected in hemorrhage from such a condition.

A dead fetus may result in concentrated thromboplastin in the amniotic fluid which can be absorbed through the viable decidua.[9] The blood should be checked to see if an adequate clot will form. This should be done twice weekly in such cases, or blood fibrinogen determinations performed. If the fibrinogen level approaches a critical point, the patient should be admitted to the hospital and prophylactic measures taken.[9]

Active treatment includes the correction of the defective clotting mechanism. Fresh citrated blood has been recommended.[9] Fibrinogen is effective. The amount recommended varies from 4 to 12 gm.[9, 10] The use of blood may require some consideration, due to the presence of cor pulmonale in severe cases.[8] Some believe blood can be used freely and recommend 10 cc. of a 10% calcium gluconate with each 2,000 cc. of blood.[9] One patient received 30 transfusions in eight hours and expired.[2]

Premature operative interference is considered dangerous. The patient should be resuscitated and the clotting mechanism corrected first.[9] Artificial rupture of the membranes will prevent further reduction of the fibrinogen content of the blood.[9] Removal of the uterine contents in postpartum hemorrhage is beneficial for similar reasons, but only after the coagulation mechanism has been corrected.[9]

Artificial respirations so that there is a relatively wide chest excursion permit survival when lethal injections of thromboplastin and meconium are given in animals.[8] Therefore, it is believed this procedure is important in clinical cases.

It should be remembered that the severe anaphylactoid reaction is fleeting in character. The patient can survive if life can be supported for a brief period.

Summary

A case in which the patient had a routine cesarean section is presented. Postoperative hemorrhage from the region of the tubal ligation developed. The patient's blood pressure was unobtainable after the second operation but was elevated to 132/80 shortly after surgery. She was operated upon a third time because of hemorrhage. An obvious coagulation defect of the blood was noted at that time. One fibrinogen determination was performed. It showed the fibrinogen to be at the critical level, and 2 gm. of fibrinogen was given just before the second operation.

The postmortem examination showed a considerable amount of incoagulable blood in the subcutaneous tissue, with extravasated blood subperitoneally. There was free blood in the peritoneum. There was atelectasis present. This should be avoided by instituting artificial respirations with wide excursions of the chest. The fibrin emboli in the lungs were from the absorption of thromboplastin which could have been from the decidua, placenta, or amniotic fluid. This resulted in afibrinogenemia and the presence of plasmin. Plasmin reduces those factors concerned with the coagulation of the blood such as prothrombin, fibrinogen, and fibrin.

Therapy should be divided into prophylactic and active measures. The details have been presented. Operative procedures should be avoided until coagulation of the blood has been restored. Hysterectomy is probably seldom, if ever, indicated.[2]

The adequate aeration of the lungs by wide chest excursion is important in management.

Levophed does not activate plasminogen in dogs. Plasmin is present in humans after the injection of Adrenalin. This would cause an unstable clot.

In the case presented ciliated epithelium from the fallopian tubes was noted in the capillaries of the lungs. Such a finding has not been recorded previously as far as we know. This merely demonstrates how open vessels can absorb tissue and tissue extracts. The absorption of thromboplastin caused the afibrinogenemia in this case. The condition developed in the absence of amniotic fluid epithelial cells in the lungs. This indicates that the cellular elements are not always the important factor in this condition.

St. Luke's Memorial Hospital.

REFERENCES

1. Dastre, A.: Fibrinolyse dans le sang, Arch. de physiol. Norm. et path. 5. s., 5:661–663, 1893.
2. Weiner, A. E., Reid, D. E., and Roby, C. C.: Incoagulable blood in severe premature separation of placenta: method of management, Am. J. Obst. & Gynec. 66:475–499 (Sept.) 1953.
3. Macfarlane, R. G., and Biggs, Rosemary; Observations on fibrinolysis, spontaneous activity associated with surgical operations, trauma, etc. Lancet 2:862–864 (Dec. 14) 1946.
4. Biggs, Rosemary, Macfarlane, R. G., and Pilling, J.: Observations on fibrinolysis; experimental activity produced by exercise or adrenaline, Lancet 1:402–405 (March 29) 1947.
5. Macfarlane, R. G., and Biggs, Rosemary: Fibrinolysis; its mechanism and significance, Blood 3:–1167–1187 (Oct.) 1948.
6. Olson, E. S., Wenzler, J. M., and Jewell, R. J.: Unpublished data.
7. Tagnon, H. J., Levenson, S. M., Davidson, C. S., and Taylor, F. H. L: Occurrence of fibrinolysis in shock, with observations on prothrombin time and plasma fibrinogen during hemorrhagic shock, Am. J. M. Sc. 211:88–96 (Jan.) 1946.
8. Schneider, C. L., and Engstrom, R. M.: Experimental pulmonary arterial occlusions: acute cor pulmonale simulating "obstetrical shock" of late pregnancy, Am. J. Obst. & Gynec. 68:691–705 (Aug.) 1954.
9. Kinch, R. A. H.: Hypofibrinogenemia in pregnancy and puerperium, Am. J. Obst. & Gynec. 71:746–753 (April) 1956.
10. Reid, D. E., Weiner, A. E., and Roby, C. C.: Intravascular clotting and afibrinogenemia, presumptive lethal factors in syndrome of amniotic fluid embolism, Am. J. Obst. & Gynec. 66: 465–474 (Sept.) 1953.
11. Mallory, G. K., Blackburn, N., Sparling, H. J., and Nickerson, D.: Maternal pulmonary embolism by amniotic fluid; report of three cases and discussion of literature, New England J. Med. 243:583–587 (Oct. 19) 1950.
12. Jennings, E. R., and Stofer, B. E.: Pulmonary emboli composed of contents of amniotic fluid, Arch. Path. 45:616–621 (May) 1948.
13. Shotton, Dorothy M., and Taylor, C. W.: Pulmonary embolism by amniotic fluid (report of fatal case, together with review of literature), J. Obst. & Gynaec. Brit. Emp. 56:46–53 (Feb.) 1949.
14. Stone, S., Koucky, R., and Leland, H. R.: Fatal case of amniotic fluid embolism, Am. J. Obst. & Gynec. 70:660–662 (Sept.) 1955.
15. Crowder, R. E., and Bills, E. S.: Obstetric shock due to pulmonary emboli of amniotic fluid, Obst. & Gynec. 60:1388–1389 (Dec.) 1950.

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FISKE ESSAY ON INFERTILITY

The trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announce as the subject for this year's dissertation "The Present-Day Treatment of Infertility." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $350 is offered. Essays must be submitted by January 10, 1957.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Autohemotherapy—An Effective Treatment for Herpes Zoster

By FRED J. ANSFIELD, M. D., Glidden and JOHN L. RENS, M. D. Phillips

Introduction

THE ordinary case of herpes zoster is first seen and treated by the general practitioner, who usually follows the case through to an eventual cure. That the methods of treatment of this malady are still so numerous and diverse gives evidence to the fact that through the years we have made little progress in its management. Occasionally the family physician will attempt every treatment which has been described until he realizes that the herpes zoster, after months of stubborn unresponsiveness, has developed into a chronic postherpetic neuralgia. It is in such cases that a patient will then perhaps be referred to a neurosurgeon. Van Blaricom and Horrax[1] have recently described the radical surgery, from lobotomy to chordotomy, that has been done in an attempt to relieve the suffering from this agonizing neuralgia. They make the plea that "medical attention should be focused on the preventive aspect of postherpetic neuralgia by perfecting the measures to reduce the severity of the acute attack."

Among the newer methods of treatment of herpes zoster, including the use of Chloromycetin or Aureomycin, is the use of gamma globulin; a very interesting report describing the effective treatment of 5 patients with this method was made by Weintraub.[2] In 1942, J. W. Nixon–Davis, M.D., of Chicago informed one of us (J.L.R.) that injecting a patient's own blood intramuscularly was the treatment of choice in dealing with herpes zoster. Since that time we have treated a total of 54 cases of herpes zoster by intramuscular injections of 15 cc. of the patient's own blood. The diagnosis was established in each case only after the typical herpes made their appearance and the distribution of the lesions involved the usual locations—occipital, thoracic, abdominal, lumbar, or extremity.

	No. of Cases	Results	Duration of Pain after First Injection
One injection, 15 cc. patient's own blood	8	Excellent	2 days or less
Two injections	34	Excellent	4 days or less
Three injections	12	Excellent in 10	7 days or less
		1 failure responded to 2 injections of 1,000 mcg. vitamin B_{12}	13 days
		1 failure cleared spontaneously	3 months

Method and Results

At the time the diagnosis was made, 15 cc. of blood was withdrawn from the antecubital vein of the patient and injected deep into the gluteal muscle on one side. The patient was instructed to return in 48 hours. If the pain had entirely subsided, no further treatment was given. Eight patients were in this category. The response of the vesicles went hand in hand with that of the subjective symptom of pain. On the second visit, if the patient still had pain, a second injection of 15 cc. of his blood was given in the opposite gluteal muscle, and he was instructed to return in 48 hours. If the pain had subsided then, no further treatment was given. Thirty-four patients were cured after this second injection. After two such injections at 48-hour intervals, 12 patients still had painful herpes zoster and were given a third injection of 15 cc. of their blood and instructed to return again in 48 hours. In 10 of these 12 patients requiring a third injection, the pain had subsided and the vesicles were clearing rapidly; but 2 patients failed to respond to all three injections. One of these patients was given two injections of 1,000 micrograms of vitamin B_{12}, which apparently cleared the pain promptly. The other patient was likewise given vitamin B_{12} injections following failure to respond to autohemotherapy, but there was no response to vitamin B_{12} either. The pain gradually

subsided spontaneously during the next three months.

No attempt is being made in this paper to delve into the rationale of this therapy other than to raise the question whether autohemotherapy liberates or stimulates a patient's own gamma globulin to combat the virus considered by many to be the etiological agent in herpes zoster. There were no reactions from autohemotherapy other than some local discomfort at the site of the injection; and there is no expense to the patient for his own blood, in contradistinction to the high cost of gamma globulin or moderately high cost of broad-spectrum antibiotics.

Summary and Conclusion

A series of 54 patients with herpes zoster were treated by us during the past 14 years by autohemotherapy. The results were most gratifying in 52 cases, with the pain entirely controlled within two to seven days. We feel these results are unsurpassed and heartily urge that autohemotherapy be used routinely in treating herpes zoster.

REFERENCES

1. Van Blaricom, L. S., and Horrax, G.: Chronic postherpetic neuralgia, J.A.M.A. 161:511–515 (June 9) 1956.
2. Weintraub, I.: Treatment of herpes zoster with gamma globulin, J.A.M.A. 157:1611 (April 30) 1955.

REGIONAL MEETING ON OBSTETRICS AND GYNECOLOGY

The Annual District Six Meeting of the American College of Obstetricians and Gynecologists will be held at the Hotel Schroeder, Milwaukee, March 7–8–9, 1957, and all Wisconsin physicians interested are welcome to attend. ***No registration fee is involved.***

Those interested in attending can secure program details by writing Wm. V. Luetke, M. D., 1023 Regent Street, Madison. The program will be completed prior to February 1, but program requests can be sent to Doctor Luetke at any time.

The meetings are not restricted to specialists in the fields of obstetrics and gynecology. Every Wisconsin physician is welcome to attend!

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twentieth annual meeting of The New Orleans Graduate Medical Assembly will be held March 11, 12, 13 and 14, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, scientific exhibits, medical motion pictures, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1957 meeting in New Orleans. On Saturday, March 16, a party composed of doctors and their families will leave from New York for the Mediterranean and Europe via plane. The itinerary includes France, Greece, Turkey, Egypt, Jerusalem, Lebanon, Syria, and Italy. Arrangements have been made for medical programs in the places visited. The official tour terminates in Rome on Friday, April 12, but arrangements may be made for independent travel to any points in Europe desired, with return to the United States by air or steamer.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

Adrenal Cortical Insufficiency

Problems of potential adrenal insufficiency during and after operation have become a major source of concern for the clinical anesthesiologist. Severe cases of unexplained shock have developed during anesthetization and, in many instances, have terminated in fatalities despite intensive therapy.

In recent years the synthesis of substances of the cortisone group has increased the knowledge of the physiology of the adrenal cortex, provided a better understanding of adrenal insufficiency, and led to improvement in its treatment. Studies have revealed the importance of a functioning adrenal cortex in the generalized body response to stress situations, including major surgery and severe trauma.[1] One of the significant findings was evidence that an intense adrenal stimulation occurred shortly after the beginning of an operation and persisted for one to two days. On cortisone withdrawal, patients demonstrated water retention and intoxication, which seemed to be of greater importance than salt deficiency from the standpoint of effective therapy.

Although the development of cortisone drugs has increased the success of treatment in many diseases, the widespread and, at times, indiscriminate use of the drugs has been cause for alarm. Cortisone compounds and ACTH act on every tissue by a mechanism which is still unknown; therefore, they must be used with extreme care.[2] Cortisone drugs depress the formation of ACTH, which stimulates the adrenal cortex, and produce adrenal atrophy or a relative insufficiency. Adrenal suppression may occur with a minimal dosage after only five days of therapy. Additional stress, such as anesthesia and operation, may lead to acute adrenal insufficiency and endanger a patient's life.

Adrenal cortical insufficiency may occur, also, in patients who have not received any hormonal therapy. Decreased tolerance to stress is found more frequently in the older age group, especially the senile; in debilitated patients who have had extensive surgery; in patients with severe urologic disorders; and in psychotic patients or those showing marked anxieties.[3] Adrenal cortical insufficiency should be suspected in all surgical patients who present the picture of severe vascular collapse in spite of adequate blood replacement or in the absence of obvious causative factors. In this category can be grouped those cases formerly classified as "irreversible shock" or "anesthesia shock." Respiratory depression and a prolonged reaction time after anesthesia may occur.

Case History

The following case history illustrates a possible type of adrenal cortical insufficiency which may occur during operation:

A 33-year-old white female was admitted to the hospital for treatment of severe epigastric pain, nausea, and vomiting of three months' duration. X-ray studies revealed a chronic duodenal ulcer, and she was prepared for gastric resection. Physical examination was essentially negative.

The patient was anesthetized with 1% Sodium Pentothal given intravenously in divided doses totaling 500 mg. Twenty milligrams succinylcholine was given and an orotracheal tube inserted without difficulty. Maintenance of anesthesia was continued with nitrous oxide, ether and oxygen mixture by semiclosed circle technique. Three 10 mg. doses of succinylcholine were given during the exploratory phase of the operation. Five hundred cubic centimeters of blood was started, and the operation proceeded uneventfully for one and one-half hours. Blood pressure was 130/96, and the pulse rate was 100. At this time sudden, severe vascular collapse developed. The blood pressure was inaudible, the pulse was thready, respirations were gasping, and the patient's skin was cold and wet. Artificial ventilation with

100% oxygen was begun. Ten milligrams Methedrine was given and the dose repeated in three minutes. Ten minutes later, 20 mg. was given intravenously with no effect on the blood pressure. Rapid transfusion of blood did not alter the patient's condition. Four cubic centimeters adrenal cortical extract was given intravenously, and the blood pressure improved, reaching a level of 144/98. During this period of hypotension there was no evidence of cyanosis. A second transfusion of 500 cc. of blood was started, and repeated injections of adrenal cortical extract sustained the blood pressure at 120/90 during the completion of the operation. The patient was observed for 20 minutes longer in the operating room and then was taken to the recovery room.

In the recovery room she received 200 mg. cortisone intramuscularly and oxygen at 6 liters per minute by oropharyngeal catheter. Repeated doses of adrenal cortical extract were given during the next hour, and the patient's general condition continued to improve. Blood pressure remained stable at 106/70, and the pulse rate was 100.

That evening the patient was returned to her own room, where she received another 200 mg. dose of cortisone. On the first postoperative day she appeared very pale. She was mentally clear but complained of feeling "numbness all over." Oxygen was continued, and 100 mg. cortisone was given twice daily for three days; then dosage was decreased to 100 mg. daily for three more days. The patient was up and about on the fifth postoperative day and was discharged on the eleventh day. When questioned about previous medications she may have received, the patient was unable to give any definite evidence that she had received hormone therapy. She had had three other operations without any apparent complications.

Much emphasis has been placed on the danger of anesthesia and operations for those persons who have had previous cortisone or ACTH therapy. Individuals concerned are prone to forget other possible etiologies of sudden shock in the operating room. Rarely does a patient develop sudden, severe vascular collapse without any premonitory warning signs. Hypercarbia or hypoxia are most dangerous, and they can develop insidiously. A gradually developing cyanosis often goes unobserved.

However, if it is assumed that this patient's ventilation was adequate, the possibility of a decrease in circulating adrenal cortical hormone cannot be overlooked. When severe shock develops despite adequate blood replacement and adequate oxygenation, it is reasonable to assume that an adequate supply of adrenal cortical hormone is unavailable. There is usually a failure of response to vasopressors, and in this state of temporary insufficiency the administration of cortisone or related compounds may be a lifesaving measure.

Adrenal cortical insufficiency developing during operation can be treated most rapidly by the intravenous administration of 100 mg. hydrocortisone sodium succinate dissolved in 2 cc. sterile water. Two hundred milligrams cortisone also is given intramuscularly; and after the patient regains consciousness, 100 to 200 mg. doses may be given orally every four to six hours for several days with gradual tapering off. Systolic blood pressure should be maintained about 100 mm. Hg. by an intravenous norepinephrine solution until the cortisone takes effect. Blood lost must be replaced.[4]

Prophylactic preparation consists of the administration of 200 mg. cortisone intramuscularly 48, 24, and 1 or 2 hours before the operation. Doses of the drug are gradually decreased during the next three to four days and then stopped. Only half the normal preoperative medication is given. Postoperatively, blood pressure and pulse rate should be recorded hourly for 24 hours. The patient should receive 1,000 cc. saline or 5% dextrose in saline during the first 24 hours, with total fluid intake not exceeding 1,500 cc. during that period.

Adrenal cortical insufficiency is cured with difficulty once it has developed immediately after an operation. Every means possible should be taken in advance to determine the patient's status. A carefully taken preoperative history and physical examination may give important information. The anesthesiologist must make his own inquiry from every patient regarding any previous cortisone therapy, the appearance of hypotension during past operations, and prolonged reaction time following anesthetization. The potential hazard cannot be overemphasized. Any patient who has received significant

amounts of a cortisone compound within three to six months prior to the operation may have adrenal insufficiency and should be treated prophylactically. Likewise, patients fitting the categories listed above must be evaluated carefully and treated in advance. Sudden and dangerous hypotension may develop and may not respond to palliative therapy. Cortisone compounds are the specific remedy.

REFERENCES

1. Root, Benjamin: Postoperative adrenal insufficiency: review, Anesth. & Analg. 34:78–95 (March–April) 1955.
2. Romagnoli, A. G. F.: Cortisone and anaesthesia, Canadian Anaesthetists' Society Journal 2:255-262 (July) 1955.
3. Howland, W. S., Schweizer, Olga, Boyan, C. P., and Dotto, Alma C.: Treatment of adrenal cortical insufficiency during surgical procedures, J.A.M.A. 160:1271–1273 (April 14) 1956.
4. Pender, J. W.: Complications in anesthesia related to cortisone therapy, Wisconsin M. J. 53:215–218 (March) 1954.

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2. **Civil Defense Manual for Mobile Medical Team Personnel**—An explanation of the Wisconsin program for civil defense and the role of mobile medical teams in that program.
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Services of District Health Officers

As It Looks to Your State Board of Health

THE State Board of Health was established by the legislature through the efforts of the State Medical Society in 1876. As knowledge increased and living standards were raised, it became increasingly apparent that having the administrative agency based in Madison caused unavoidable delays and difficulties in providing the services for which the department was created.

Therefore, in 1936 the Board of Health divided the state into nine districts with an office in each area, staffed with a nucleus of a public health physician, nurse, engineer, and a secretary. In 1952 reorganization resulted in eight districts. Each is composed of from 8 to 15 counties, with geography and population determining the boundaries.

The primary function of the district office is to provide the services of public health specialists in a consultative or advisory capacity to local governmental units such as counties, cities, villages, and townships; local boards of health and health departments; and school systems and other agencies, official and voluntary, involved in local health services. The paramount guiding principle in these relationships is that the best local health service is one that is organized, paid for, and directed by the community itself. The size of the community should necessarily depend on an area and population base, financially able to support a well-trained and fully staffed health service. This would mean in some instances, a city; in others a county with smaller cities included; or in sparsely populated areas, two or more counties.

In other words, direct health services should be given by the smallest governmental unit capable of doing the job economically and effectively.

The typical district office today is in charge of a physician with postgraduate training in public health administration, epidemiology, preventive medicine, and environmental sanitation. Principal working relationships are with local governmental units, health departments, physicians, hospitals, public health nurses, and voluntary health agencies.

An advisory nurse with special training in public health nursing supervision acts in a consultative capacity, with public health nurses functioning locally in city, county, school, industrial, and visiting nursing services. Daily bedside care is given by the visiting nurses.

A sanitary engineer is responsible for environmental sanitation. This means safe public and institutional water supplies and sanitary disposal of all public and institutional wastes, including sewage, garbage, and refuse. Indoor and outdoor bathing places are under his supervision, as well as slaughterhouses and recreational camps.

A nutritionist works with hospitals and institutions in an advisory capacity on normal adequate diets and special dietary problems. Considerable time is spent in school systems aiding the integration of nutrition education in the teaching curriculum.

A dental hygienist is available to local hygienists in planning programs, conducting surveys, and evaluating results. School administrators and teachers are given assistance in dental health education.

A stream pollution control engineer surveys watersheds for contamination by municipalities, industries, and institutions. Methods of abatement are suggested, and follow-up evaluates results.

Supervision of public establishments serving food and those offering lodging, as hotels, motels, cabins, and cottages, is provided by specially trained sanitarians.

A public health sanitarian works closely with the sanitary engineer, assisting in more complicated tasks, and is also available to the general public on such problems as private water supplies and waste disposal.

It might appear that the State Board of Health responsibilities for the health needs of the people are being adequately met. The average district office, however, serves an area of from 8 to 15 counties and hundreds of thousands of people. The actual situation presents an increasingly difficult task to perform routine duties satisfactorily, and many of the more recently developed public health concepts must be postponed because of lack of time and staff.—G. M. SHINNERS, M. D., *District Health Officer, Green Bay.*

M. G. RICE, M. D.
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Radiology

Planned in cooperation with the Wisconsin Society of Internal Medicine, the Section on Ophthalmology and Otolaryngology, the Wisconsin Orthopedic Society, the Wisconsin Radiological Society, and the Milwaukee Neuro-Psychiatric Society

WATCH COMING JOURNALS FOR DETAILS!!

OFFICIAL CALL FOR

Scientific Exhibits

★

1957 ANNUAL MEETING MILWAUKEE MAY 7–8–9

★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1957 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1957 meeting are requested to file an application BEFORE FEBRUARY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and velour side runners 3′ in height. *No exhibit may exceed a height of 7′ from the floor.* If you are using material which necessitates counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) this should be taken into consideration. Because low dividers are used, *no exhibit can project more than 3′ from the back wall at either end of the exhibit.*

Spaces can be allocated in 10′ or 15′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by February 1. *No applications can be accepted after that date.* Address your communications to Melvin Huth, M. D., director of scientific exhibits, % The State Medical Society of Wisconsin, 330 East Lakeside St., Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1957 ANNUAL MEETING MILWAUKEE MAY 7-8-9

Fill Out and Mail to:

MELVIN HUTH, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
330 East Lakeside Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit:_____

2. Description of exhibit (attach 200-word description to this blank):_____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require? 10′ 15′ 20′ 30′ (Check One)
(Space is scarce so do not request more than is necessary).

4. Will radiologic viewing boxes be used? If so, will you furnish them?_____
(The State Medical Society does not have equipment of this character available).

5. Name of exhibitor:_____

6. Name of institution cooperating in exhibit: _____

ANNUAL MEETING FEATURES: MAY 7–8–9, 1956

TUESDAY: General Practice Day *(Category I credit for Academy members!)*

WEDNESDAY: Special Programs on Surgery, Obstetrics and Gynecology, Pediatrics, and Anesthesia

THURSDAY: Special Programs on Internal Medicine, Psychiatry, Ophthalmology and Otolaryngology, Orthopedics, Radiology

COLOR TELEVISION EVERY DAY: Surgery and Medicine, through Milwaukee County General Hospital: Joseph King, M. D., Chairman

Minutes of the Council Meeting, Madison February 25-26, 1956

1. Call to Order and Roll Call

The annual meeting of the Council was called to order by Chairman R. G. Arveson, M.D., at 2:00 p.m., Saturday, February 25, 1956.

The roll call showed all voting members of the Council present with the exception of Doctors Hill and Wegmann.

Officers present were: Doctors Simenstad, president-elect; Fons, speaker of the House; Kief, vice-speaker; and Gavin, Witte, Stovall, and Griffith, A.M.A. delegates.

Members of the Commission on State Departments present for the Saturday meeting were Doctors Sincock, Superior; Carey, Lancaster; Anderson, Stevens Point; Piaskoski, Milwaukee; Hutter, Fond du Lac; Tormey, Bennett, and Gearhart, Madison.

Other special guests on Saturday were Doctors Sigurd Gundersen, Edgar End, and C. M. Schroeder, and on Sunday Dr. J. S. Supernaw and Dr. C. N. Neupert.

Staff members and consultants present were Messrs. Crownhart, Ragatz, Thayer, White, Burke, and Hoops; Misses McGruer and Pyre; Donald E. Gill, the Society's C.P.A., and Mr. John White, of his office; and Robert B. Murphy, the Society's legal counsel.

2. Approval of Minutes

Minutes of the May 1, May 4, July 30–31, and October 14, 1955, meetings were approved on motion of Doctors Dessloch–Bell, carried.

3. New Business

Doctor Conway, Milwaukee Councilor, asked that there be a special explanation of the Provident group insurance program provided all members of the Society.

Doctor Curran, Councilor from the 13th District, suggested that special consideration be given to the provisions of Wisconsin Physicians Service; Doctor Dessloch added that there might be a special meeting of the Council devoted to Blue Shield and insurance problems.

4. Joseph M. Lubitz, M.D.

The secretary read to the Council a letter from Doctor Lubitz, Milwaukee, expressing his appreciation for help given with respect to his licensure in Wisconsin.

5. Assistant Treasurer

It was pointed out to the Council that a problem had arisen in connection with the handling of bonds for Wisconsin Physicians Service, a division of the State Medical Society. The Federal Reserve Bank, Chicago, would not accept Dr. N. A. Hill's signature as treasurer of W.P.S. as sufficient authority for surrendering registered bonds, since it is required that the signature be that of an officer of the corporation, which is the State Medical Society.

Therefore, it was proposed that Doctor Hill be elected an assistant treasurer of the Society to fulfill the requirements of the Federal Reserve Bank and to facilitate transactions of W.P.S.

> On motion of Doctors Bell–Curran, carried, Dr. N. A. Hill was elected assistant treasurer of the State Medical Society.

6. Advertising Policy, The Wisconsin Medical Journal

Since October, 1944, it has been the policy to accept without solicitation, advertising in *The Wisconsin Medical Journal* of alcoholic beverages. On recommendation of the Audit and Budget and Executive committees of the Council, it was moved by Doctor Ekblad and seconded by Doctor Bernhart that this action be rescinded, with authorization to the staff to solicit such advertising.

Doctor Fox, La Crosse, discussed the motion, holding that the carrying of such advertising was not a proper function in a professional journal and then recommended that the motion be defeated.

After further discussion the motion was put and carried, with Doctors Fox and Lokvam voting "no."

7. Report of the Commission on Prepaid Plans

Dr. E. M. Dessloch, chairman, presented a detailed report concerning the operations and plans of W.P.S., outlining the benefits available, experimentation being conducted in various sales efforts, and new contract terminologies.

He discussed the future in research and underwriting, Commission recommendations relative to studying the need for regional service offices, and studies to speed claim payments; and he presented an analytical report relative to the financial status of W.P.S. and a comparative statement of income and expenditures for the calendar year ending December 31, 1955.

> On motion of Doctors Galasinski–Conway, carried, the report was accepted and its distribution to delegates approved.
>
> On motion of Doctors Fox–Bell, carried, the original motion was amended to commend the Commission for the detail in which the material was presented.

8. SPECIAL ORDER: Deduction of Professional Fees as Business Expense

Councilors and officers had been provided with an opinion of the State Department of Taxation with respect to the deduction of professional fees as business expense.

Invited to discuss the subject were the president and secretary of the Wisconsin Surgical Society and of the Wisconsin Chapter of the Academy of General Practice.

Following discussion, it was moved by Doctors Bernhart–McCarey, carried, that the chairman be authorized to appoint a special committee to study the entire subject in detail.

The chairman subsequently announced the appointment of Doctors Bernhart, J. M. Sullivan, and G. W. Carlson as members of this committee.

9. Commission on State Departments

By action of the Council in May, 1955, the Commission on State Departments was invited to present its report for the prior year to the Council for its consideration (Commission members present are included in the roll call, item 1).

Dr. T. W. Tormey, Jr., general chairman, reviewed briefly the purpose and jurisdiction of the Commission and called on individual division chairmen to report on their particular activities. These reports covered maternal mortality studies, tuberculosis, plans for saving sight and sound, programs in the field of handicapped children and school health. Also reported was material relating to rehabilitation, care of the aging, and public assistance. The newly organized Division on Safe Transportation presented a summary report, with other items in this same category being presented by the Division on Nervous and Mental Diseases.

These reports were accepted and ordered forwarded to the House of Delegates. They appear in detail in the August, 1956, issue of *The Wisconsin Medical Journal.*

10. Social Security Legislation (H.R. 7225)

The following resolution was presented and discussed in detail by Mr. Robert B. Murphy, legal counsel. It was unanimously approved, on motion of Doctors Dessloch–Kasten, carried.

WHEREAS, H.R. 7225, which would amend the Social Security Act, was adopted by the House of Representatives in 1955, and is now before the United States Senate; and

WHEREAS, That bill includes provisions for disability insurance benefits beginning at age 50 in certain cases; for the continuation of insurance benefits to certain minors who were disabled before age 18; and extends coverage on a mandatory basis to all self-employed health professions, other than that of medicine, and to other professions as well; and

WHEREAS, Mrs. Oveta Culp Hobby, former Secretary of the Department of Health, Education, and Welfare, in the course of a statement before the Senate Committee on Finance on July 26, 1955, warned against the adoption of H.R. 7225 in its present form because there had not been adequate opportunity to consider certain of its provisions, to correlate them with earlier adopted portions of the Social Security system, to evaluate amendments to the Social Security Act made in 1950 and in 1954 which involved parallel fields of health or benefits, and because the bill failed to take a realistic approach to the costs of the benefits provided by it; be it therefore

Resolved, That the State Medical Society of Wisconsin, comprised of more than 3,200 practicing physicians, by its governing body, the Council, in meeting assembled at Madison on February 25–26, 1956, after careful deliberations on H.R. 7225, with particular consideration of the implications of the bill for physicians, as practitioners of medicine and as citizens, urge the Senate of the United States to defeat that bill because it contains provisions to:

1. Establish a disability insurance system for certain persons 50 or over.

2. Continue insurance benefits for minors over 18 who are disabled before attaining age 18.

3. Force self-employed professional workers in health and other fields, exclusive of medicine, into the Social Security system.

4. Propose increases in Social Security tax rates.

5. Establish an Advisory Council on Social Security Financing; and be it further

Resolved, That the basic reasons of the Council of this Society for urging the defeat of H.R. 7225 are as follows, with reference to the five provisions to which objection was made above:

1. The disability insurance system proposed for those 50 and over would be established by the bill without due consideration of the following factors, among others: (a) the size and extent of the disability problem; (b) the estimate of experts in rehabilitation and retraining that up to 97 per cent "of all handicapped persons can be rehabilitated to the extent of gainful employment"; (c) an apprehension, amply demonstrated in the veterans' program, and elsewhere in fields involving physical and psychic injury, that cash disability benefits often operate as a deterrent to rehabilitation and the return to gainful employment; (d) the implications for the Social Security program of grafting a cash

disability system of unknown, but unquestionably very substantial proportions, onto that system; (e) the requirement that physicians certify disability under the unrealistic definition contained in Section 103 of the bill, which is totally deficient in the safeguards and reference points which reduce abuse in other fields of compensable injuries. We have particular reference to the relationship to employment which must be established as a condition of recovery in workmen's compensation cases; to service connection before there can be any determination of the right to disability benefits in the veterans' program; and to the factual background which in a large number of cases is established, in part, by third persons in negligence cases; and to specific phrasing in contracts of disability insurance issued by commercial companies. Objective standards to assist in determination of disability are neither provided for nor apparently anticipated by H.R. 7225; (f) the inevitable impairment and possible destruction of the personally significant and the economically and socially desirable programs established by the federal and state vocational rehabilitation statutes; (g) the astronomical costs of the disability insurance and other provisions of the bill, which the chief actuary of the Social Security Administration estimates will add an average of not less than two billion dollars per year to the costs of that system.

2. A disability program for minors over 18 who were disabled prior to age 18 would be established without study of the problem, without weighing the federal and state machinery now available for its solution at state levels, and without regard for the other factors named in the objections offered above with reference to disability insurance for those over 50; except that this Council thinks that protest over the emphasis on cash benefits rather than training or rehabilitation programs for handicapped youth should be even more vigorous in the case of those who have not ordinarily begun their productive work than in the case of those who have spent much of their lives productively employed, as is undoubtedly true of the major portion of those disabled at or after age 50.

3. The mandatory extension of coverage to certain self-employed professional workers in 1954, and the attempted extension of coverage on a mandatory basis to all the remaining self-employed professional workers, with the exception of physicians, in H.R. 7225 is believed unrealistic in that it violates the actual pattern of productive activity of professional workers, and unjust because it is an ill-disguised method of tapping the incomes of such persons in full realization that the professional self-employed, as a group, will not derive benefits from the Social Security system proportionate to the taxes paid by them. While the medical profession is fully cognizant that it is the sole professional group remaining exempt, should H.R. 7225 be enacted in its present form, this Council regards such an exemption as nothing more than a reprieve rather than as a continuing exemption from mandatory coverage. The Council expresses the further observation that the financing of the Social Security system has become in effect a gross income tax which will have no income ceiling if the benefits continue to rise as they did in 1950, 1952, and 1954.

4. The objection to the rates proposed is that they are not increased sufficiently to equal the true cost of the benefits, and that they represent a continuation of the pattern which the Congress has followed consistently since 1939, of adding time after time to benefits without adding proportionately to the taxes assessed to pay for those benefits. In light of the evidence already placed before the Congress to the effect that the present Social Security Trust Fund is not adequate to pay benefits to present beneficiaries, much less to establish reserves for the time when present contributors, or their families, will themselves become the beneficiaries of the Act, it is believed essential to the very integrity of the basic Social Security program and to its direct and indirect influence on the country's economy to make adequate changes in the tax rates rather than to continue temporizing with these vast obligations which will rapidly and inevitably fall due, and which are estimated at two hundred eighty billion dollars at this time.

5. Although the establishment of the Advisory Council on Social Security Financing "for the purpose of reviewing the status of the Federal Old-Age and Survivors' Insurance Trust Fund in relation to the long-term commitments of the old-age and survivors insurance program," as provided in Section 107 (a) is a step in the right direction, the Council objects to this provision on the basis that it does not go far enough. It is doubted whether such an advisory council would have jurisdiction over a number of the basic provisions of H.R. 7225 to which exception has been taken earlier in this resolution. It is believed

much more relevant and fundamentally sound for the Congress to make no further changes whatever in Social Security legislation until it has first authorized and either conducted or arranged for an impartial study of the Social Security system as it now exists, the direction which it is taking, and the complete costs of the system, however it is to be continued, and be it further

Resolved, That the provisions in H.R. 7225 to which exception has earlier been taken in this resolution are believed to be of such a fundamental nature that they do not admit of compromise, and should in no event be enacted into law before a genuine and objective study has been completed by the Congress and the Department of Health, Education, and Welfare, and the full findings of such study have been made public, with adequate time for evaluation and reactions by the public. It is believed that if the Social Security system is to continue on a sound basis and is to fulfill its two original purposes; namely, to provide a basic pension for workers who have been taxed by the program, and survivorship benefits to the families of such workers, and if the substantial inflationary elements in the current administration of the Social Security program are to be kept under control, the time required for such a study must be taken without further delay, and the future of the program plotted in light of such findings, and be it finally

Resolved, That copies of this resolution be sent to the two United States Senators from Wisconsin, to each Wisconsin Congressman, and to the Committee on Finance of the United States Senate.

11. Salk Vaccine Against Poliomyelitis

C. N. Neupert, M.D., state health officer, reported on the current status of distribution of the Salk vaccine and summarized area situations in which county medical societies had questioned public polio clinics.

There was general discussion as to the availability of the vaccine and the increased rapidity with which it was being made available, and Doctor Neupert pointed out that, in fact, under the plan of the State Board of Health, 90% of the initial polio vaccine available had been reserved for administration through the facilities of physicians' offices.

After further discussion, the general consensus of the Council was that the matter had been handled effectively and in proper public health interest.

12. Election of Officers

The next order of business was election of officers, and President E. L. Bernhart, Milwaukee, presided.

a. **Chairman of the Council.** Doctors Dessloch and Curran nominated Doctor Arveson to succeed himself as chairman and asked that the nominations be closed, instructing the secretary to cast the unanimous ballot for Doctor Arveson, who was then elected chairman.

b. **Treasurer.** Doctors Galasinski and Ekblad nominated Doctor Weston to succeed himself as treasurer and asked that the nominations be closed, instructing the secretary to cast the unanimous ballot. Dr. F. L. Weston was re-elected treasurer.

c. **Assistant Treasurer.** Doctors Dessloch and Galasinski nominated Dr. H. Kent Tenney, Madison, to succeed himself as assistant treasurer and asked that the nominations be closed, instructing the secretary to cast the unanimous ballot for Doctor Tenney, who was re-elected.

d. **Secretary of the Society and of the Council.** Doctors Dessloch and Galasinski nominated Mr. C. H. Crownhart, Madison, to succeed himself as secretary, and, there being no other nominations, the motion was put and carried unanimously.

e. **Medical Editor, The Wisconsin Medical Journal.** Doctors Galasinski and James nominated Dr. R. S. Baldwin, Marshfield, to succeed himself as medical editor and asked that the nominations be closed, instructing the secretary to cast the unanimous ballot. Doctor Baldwin was re-elected.

f. **Editorial Director, The Wisconsin Medical Journal.** Doctors Arveson and Galasinski nominated Dr. J. M. Sullivan, Milwaukee, to succeed himself as editorial director and asked that the nominations be closed, instructing the secretary to cast the unanimous ballot for Doctor Sullivan, who was then re-elected.

On motion of Doctors Ekblad–Conway, carried, the Council voted to commend Doctors Baldwin and Sullivan for their splendid efforts in connection with publication of the Journal.

13. 1956 Budget as Reported by the Audit and Budget Committee

There was submitted to the Council the total operating budget, including travel and payroll of the State Medical Society of Wisconsin, Wisconsin Physicians Service, and the S.M.S. Realty Corporation.

All administrative expenses were presented in total, and the budget was so presented as to show 28 administrative classifications accounted for by general administration, Grievance Committee, field representation, officers', Council and Commission meetings, membership, accounting, public health information, annual meeting, teaching clinics, *The Wisconsin Medical Journal,* public information, sales, claims, statistics, and machine service.

The total budget for these activities was $988,007, including payroll and without income offsets such as advertising in *The Wisconsin Medical Journal* and

exhibits at the annual meeting. The net budget submitted was $919,605 for the State Medical Society and Wisconsin Physicians Service, and $70,600 for operation of the S.M.S. Realty Corporation.

The following administrative salaries were approved by the Council:

Secretary, C. H. Crownhart	$25,000
Assistant Secretary, E. R. Thayer	12,000
Assistant Secretary, W. C. White, Jr.	15,000
Assistant Secretary, R. T. Ragatz (⅓ time)	5,000

All executive, executive assistant, and administrative assistant salaries were reviewed in detail, with stenographic and clerical salaries accepted as presented.

On motion of Doctors Garrison–Bell, carried, the 1956 budget was approved as amended.

Doctor Arveson expressed to Doctor Dessloch the appreciation of the Council for his presentation of the budget and his work with the Audit and Budget Committee.

14. Veterans Medical Service Agency

Dr. J. S. Supernaw, chairman of the V.M.S.A. Operating Committee, presented the following communication received from Dr. W. S. Middleton, chief medical director of the Veterans Administration:

Doctor Ervin L. Bernhart, President
State Medical Society of Wisconsin
2714 West Burleigh Street
Milwaukee, Wisconsin

Dear Doctor Bernhart:

I wish to bring to your personal attention as president of the State Medical Society of Wisconsin a matter which I deem to be of considerable importance to you and to the membership of the Society.

As you know, contracts have been negotiated between the Veterans Administration and intermediaries designated by state medical societies whereby out-patient services are provided to eligible veterans by private physicians. These agreements were made following World War II to assist in carrying out administrative practices required in connection with the Veterans Administration Home Town Care program.

In eight states, including Wisconsin, where the Wisconsin Veterans Medical Service Agency acts as intermediary between your organization and the Veterans Administration, third-party agreements are presently in force. In my opinion, intermediaries have contributed substantially to the advancement of our out-patient medical activities especially during the postwar period. In recent years, however, the Home Town Care program has become well stabilized with the result that the need for intermediary arrangements has diminished progressively. Current survey reports demonstrate that under this third-party type of operation there is much unavoidable duplication of effort.

During the fiscal year 1955 more than $350,000 was expended to cover administrative costs incurred by intermediaries in discharging responsibilities defined in contracts with the Veterans Administration. These expenditures exclude, of course, payments to participating physicians for services rendered eligible veterans. It is evident that a more efficient operation would result through elimination of such third-party agreements.

I have concluded, therefore, that it will serve the best interests of state medical societies, veterans, and the Government to terminate all existing contracts with the intermediaries no later than July 1, 1957. It is my hope that this measure may be undertaken on a cooperative basis with the full concurrence of the sponsoring medical society and the intermediary. Cancellation of contracts now in force will permit the Veterans Administration to utilize available resources more efficiently in providing fee-basis medical services to former members of the Armed Forces.

In the absence of an intermediary, it has been our practice generally to negotiate an agreement . . . with the state medical society concerned. Under the terms of such agreements, physicians who desire to participate in the Home Town Care program on a fee-basis are authorized to perform services by the Veterans Administration field station of jurisdiction and reimbursement is effected by that office. The fee schedule, jointly approved by the medical society and the Veterans Administration, is made a part of this agreement. In Wisconsin, the current fee schedule would remain in effect if a direct agreement were consummated as described above.

Your kind cooperation in bringing this matter to the attention of interested officers and members of the State Medical Society of Wisconsin will be greatly appreciated.

Very truly yours,
WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

Following discussion the matter was laid over until the July, 1956, meeting, on motion of Doctors Bernhart–Bell, carried.

15. Provident Insurance Program

After discussion on Doctor Conway's request for details on the Provident insurance program offered to members, it was determined that the matter should be taken up at a subsequent meeting of the Council.

16. Report of the Executive Committee

a. The Executive Committee recommended that Dr. Frederick Shideman be elected an honor-

ary member of the State Medical Society. It was also recommended that Doctor Shideman be elected co-editor of the Journal's page "Comments on Treatment."

On motion of Doctors Dessloch–Fox, carried, the recommendation was approved.

b. On recommendation of the Executive Committee a report of the Council on Medical Service relative to increased tendencies on the part of hospitals to exceed the accepted and established spheres of their activities was considered. After discussion, the report was approved, on motion of Doctors Bernhart–McCarey, and re-referred to the Council on Medical Service for further study and implementation.

17. Senior Class Day Programs

Senior class day programs in the medical schools in Wisconsin, sponsored by the Society, with a social hour provided through the courtesy of Mead Johnson & Company, were approved on motion of Doctors Dessloch–Kasten, carried.

18. Resignation of Mrs. Helen B. Supernaw

The Council was informed of the resignation of Mrs. Supernaw, who had served the State Medical Society as a secretary, assistant editor of *The Wisconsin Medical Journal*, membership clerk, and director of membership services, in these varying capacities since 1937. On motion of Doctors Bernhart–Galasinski, carried, the secretary was instructed to present a suitable token of esteem on behalf of the individual members of the Council and officers, the costs thereof to be borne by them individually.

19. Medical Care Plans

After discussion, and on motion of Doctors Bell–Galasinski, carried, the Council instructed that the staff prepare a special joint meeting of the Commission on Prepaid Plans and the Council, to consider the past, present, and future of prepaid insurance in Wisconsin.

20. Adjournment

There being no further business, the 1956 annual meeting of the Council adjourned at 12:30 p. m., Sunday, February 26.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M. D.
Chairman of the Council

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATION

The next scheduled examination (Part I), written, for all candidates will be held in various cities of the United States and Canada and in military centers outside the continental United States on Friday, February 1, 1957, at 2 p.m.

Candidates must submit case reports to the office of the secretary within 30 days of being notified of their eligibility to Part I. The cases must be prepared in the manner described in the Bulletin of the Board with a duplicate index list.

Requests for re-examination in Part II must be received prior to February 1, 1957.

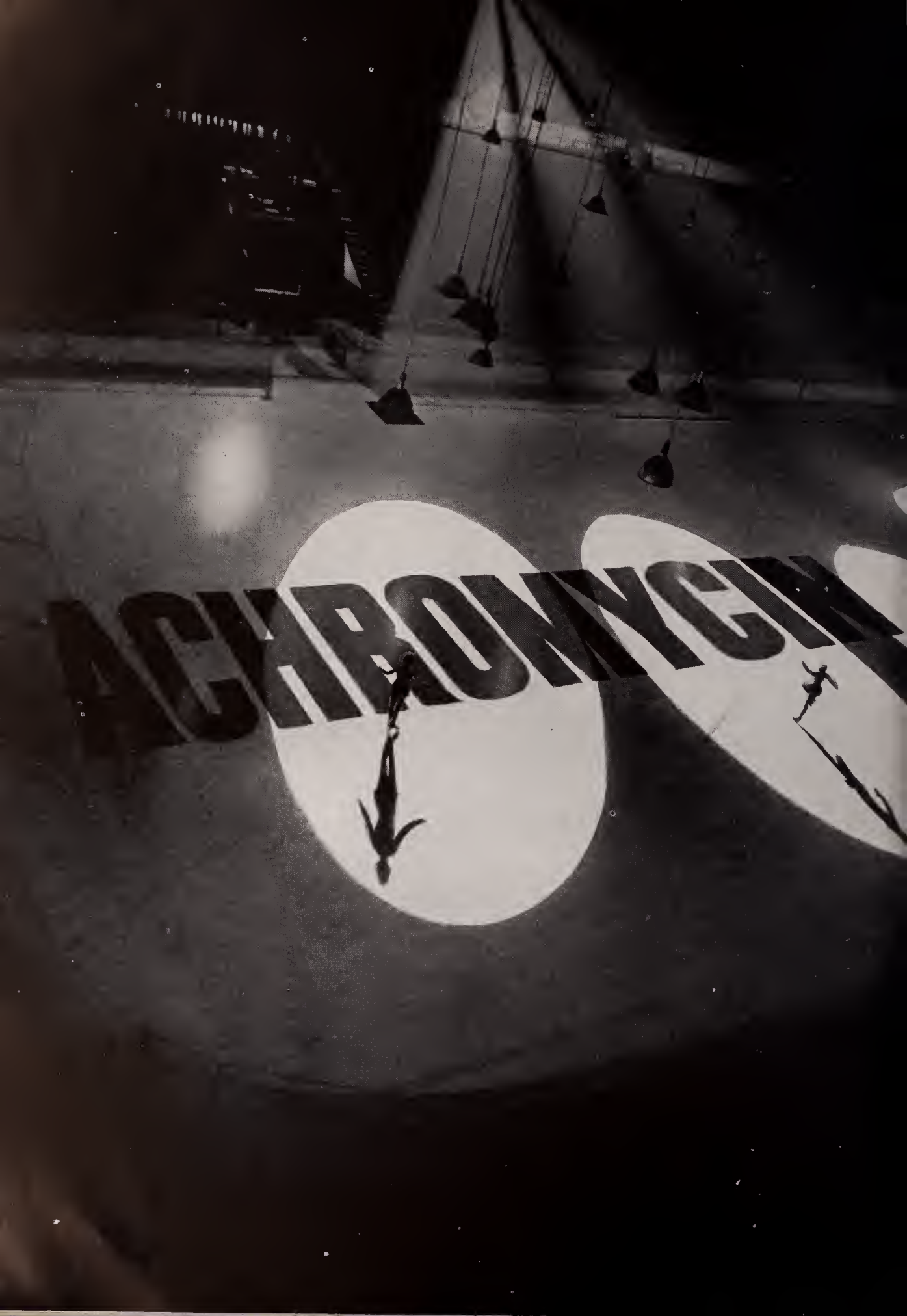
Current bulletins outlining present requirements may be obtained by writing to:

Robert L. Faulkner, M. D., Secretary
American Board of Obstetrics and Gynecology
2105 Adelbert Road
Cleveland 6, Ohio.

OF VALUE TO YOU, DOCTOR . . .

and to your patients, too, are the new prenatal fact forms developed by the Division on Maternal and Child Welfare. Designed to alert the hospital to proper care when your patient is admitted for delivery, the form is intended to encourage a closer working relationship between physicians and hospitals. Thus optimum care is possible.

The forms are available in pads of 100. The price is $2. Write to:
The Division on Maternal and Child Welfare
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin


ACROBATICS

ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

in the treatment of

genitourinary infections

UROLOGISTS report the decided advantages of oral efficacy, minimal side effects, and wide range antibacterial activity offered by ACHROMYCIN in the treatment of urinary tract infections.

Finland's[1] group of patients with acute infections of the urinary tract (principally *E. coli)* demonstrated excellent response, both clinical and bacteriological, following administration of tetracycline.

Prigot and Marmell[2] reported 49 out of 50 patients with gonorrhea showed a negative smear and culture on the first post-treatment visit. Purulent discharge disappeared in these patients within 24 hours after a usual 1.5 Gm. dose of tetracycline.

Trafton and Lind[3] found tetracycline (ACHROMYCIN) an effective antibiotic for treating many urinary tract infections caused by both Gram-negative and Gram-positive organisms.

English, *et al.*[4] noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

To suit the needs of your practice and to further the patient's comfort ACHROMYCIN is offered in a complete line of 21 dosage forms.

LEDERLE LABORATORIES DIVISION
AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

Lederle

*REG. U. S. PAT. OFF.

References:
1. Finland, M., *et al.*: *J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.*: *idem* 4:441 (April) 1954.

Minutes of the Council Meeting, Milwaukee April 29, 1956

1. Call to Order and Roll Call

In the absence of Dr. R. G. Arveson, chairman, on European tour, Dr. E. L. Bernhart, president, called the meeting to order at 2:15 p.m., Sunday, April 29, in Milwaukee.

The roll call showed all voting members of the Council present except Doctors Hill, Arveson and Wegmann. Officers present were Doctors Simenstad, president-elect; Weston, treasurer; Fons, speaker; Kief, vice-speaker; and Doctors Gavin, Witte, Stovall and Griffith, delegates to the AMA.

Guests present were Drs. C. N. Neupert, J. M. Sullivan, W. J. Fencil, E. D. Schwade, T. A. Leonard, Maurice Hardgrove, R. S. Baldwin, J. S. Devitt and Meyer Fox. Also present was Mr. R. R. Rosell, executive secretary of the Minnesota State Medical Association.

Staff and consultants present were Messrs. C. H. Crownhart, W. C. White, Jr., R. T. Ragatz, E. R. Thayer, J. F. Burke, Misses McGruer and Pyre; and Mr. Robert B. Murphy, the Society's legal counsel.

2. Committee on Diabetes

The Commission on State Departments referred to the Council a suggestion it had received that the State Medical Society create a committee on diabetes to further the education and detection aspects of the diabetic problem in Wisconsin. There exists in this state a diabetes association which has engaged in a considerable amount of activity.

The Council, on motion of Doctors Galasinski–Heidner, carried, authorized the creation of a special Committee on Diabetes, with five members, not necessarily councilors, appointment to be made by the chairman of the Council.

3. Councilor District Meetings

The Council approved, on motion of Doctors McCarey–James, carried, that a communication be directed to councilor districts suggesting the elimination of scientific programs in the months immediately prior to the annual meeting, with any such meetings to be devoted to a caucus of delegates, and special programs on matters of medical economics, medical-legal topics and topics expected to come before the House of Delegates.

On further motion of Doctors Heidner–Ekblad, carried, the motion as adopted was amended to provide that there also be associated with such meetings one to include county medical society officers and delegates within the district.

4. Clinical Psychologists

After hearing a presentation by Dr. E. D. Schwade, Milwaukee, on behalf of the Division on Nervous and Mental Diseases of the Commission on State Departments, in which he discussed the certification of clinical psychologists, the Council voted, on motion of Doctors Bell-Heidner, carried, that the Society's position be one of opposition to licensure or certification by law, and also one of encouragement to voluntary certification of clinical psychologists through the mechanisms of such practitioners. The motion included direction to refer the matter to the House of Delegates. (For further details, see proceedings of the House as printed in the August, 1956, issue of *The Wisconsin Medical Journal.*)

5. Principles of Medical Ethics

The Council considered the revision proposed by committees of the American Medical Association on the subject of the "Principles of Medical Ethics and Precepts of Manners." Earlier action by the Council and by the AMA was considered.

The Council suggested to the Wisconsin representatives to the AMA House of Delegates that they seek appropriate action toward amendment of the Principles only on the condition that such amendments have been introduced in a prior session of the House.

6. Dues of the American Medical Association

On recommendation of the Executive Committee, the Council instructed a communication to the American Medical Association to the effect that rather than increasing dues, it undertake a program to encourage mandatory membership in the organization. This was on motion of Doctors Galasinski and Carlson, carried.

7. Report of the Maternal Mortality Study Committee

Dr. T. A. Leonard, Madison, was called upon to report on the work of the Study Committee. He said, "it has been felt that the efforts of the Study Committee have been of sufficient accomplishment during the past three years to warrant a special report on some of the things that have gone on." Doctor Leonard then presented his report, which is printed in detail in the House proceedings, August, 1956, issue of *The Wisconsin Medical Journal.*

In conclusion Doctor Leonard stated his belief that the results of the three years' work have fully justified the time, effort and money involved, and said he hoped the study could be continued with Council approval.

Doctor Bernhart stated that the committee was to be commended for its work, and Doctors Bell–Ekblad so moved, with the report being accepted and referred to the House of Delegates.

The Council recessed at 4:15, after which the following actions were taken.

8. Commission on State Departments

The Council proceeded to the election of a general chairman of the Commission on State Departments and chairmen of each of its ten divisions. These elections are found on page 847, August issue of *The Wisconsin Medical Journal*, as part of the House proceedings, in the supplementary report of the Council.

9. The Wisconsin Medical Journal

Dr. R. S. Baldwin, Marshfield, Medical Editor of *The Wisconsin Medical Journal*, presented the report of the Editorial Board, which had met in session previous to the Council meeting. He reviewed editorial policies and scientific content of the *Journal*, and said the main objective of the board was to preserve and elevate the scientific value of both the Society and its official publication. He discussed such details as paging and arrangement of the publication, the preparation of manuscripts, policies with respect to articles on controversial material affecting the profession, manuscripts submitted by non-members, requests for a page or section in the *Journal* by other organizations, and the editorial page.

On motion of Doctors Heidner-Fox, carried, the Council accepted the report with thanks.

10. Student AMA, University of Wisconsin

In his capacity as advisor to the University of Wisconsin Chapter of the Student AMA, Dr. W. J. Fencil, Monroe, reported that it had just completed a successful year of activities, with 97% of the medical students as members. He commented on their dues and various activities, and on the close relationship between their group and the state and county society representatives. He said that the students had done a good job of demonstrating individual leadership and that they should have the continued support and help of the profession and the State Society.

11. Report of the Secretary

The secretary presented the problem in assigning jurisdiction of difficulties arising within the state. He said that he normally took to the Grievance Committee those problems which concern medical ethics and medical abilities; while the Committee on Hospital Relations considered the general problem of division of responsibilities between the medical staff and the hospital organization. He reported on several situations in the state in considerable detail.

The report was accepted with confirmation of staff assignment.

12. Student AMA, Marquette University

Dr. J. S. Devitt, advisor to the Marquette Chapter of the Student AMA reported that it was very gratifying to be able to report to the Council that the chapter continues to exhibit unmistakable signs of health and growth. He said that the members have taken an active part in the national meeting and show energy and spirit in its membership accomplishments. He discussed the projects and activities of the chapter and in summary said, "the SAMA, as demonstrated by its chapter in our two state medical schools, has firmly established its value to organized medicine, and merits our continued support, cooperation and encouragement."

The Council recessed for dinner at 5:45 p.m. and reconvened at 7:50 p.m.

13. Hearing Conservation Program

Dr. Meyer Fox, Milwaukee, reviewed the Hearing Conservation Programs for Wisconsin Industries, developed by the State Medical Society, and first approved in 1954. He pointed out that the problem of occupational hearing loss has become important as far as occupational disease is concerned, and reviewed the history of the development of the brochure. Doctor Fox outlined minor changes necessitated to bring the brochure up to date and recommended their approval.

On motion of Doctors Heidner–Galasinski, carried, the Council accepted the report and approved the guide as revised. It also recommended the continued sponsorship and distribution of the brochure.

14. Ophthalmologic-Optometric Relations

The Council received a report from the Public Relations Committee of the Section on Ophthalmology of the AMA, suggesting that this particular subject be discussed in forthcoming meetings of the State Medical Society of Wisconsin.

On motion of Doctors Heidner–Fox, carried, the letter was referred to the Division on Hearing and Visual Defects of the Commission on State Departments.

15. Council on Scientific Work

A staff recommendation that the Council on Scientific Work be asked to join with the General Council at its July, 1956, meeting was approved, on motion of Doctors Ekblad–Curran, carried.

16. Sears-Roebuck Foundation

This organization has a program to assist in the establishment of various medical practices with loans up to $25,000. Among other conditions imposed is that the location is logical and will have community value. The State Medical Society will be consulted.

The Council instructed that such expressions of opinion could be made on authority of the Councilor in the area involved.

17. Washington-Ozaukee County Medical Society

The Washington–Ozaukee County Medical Society had enacted amendment to its constitution and by-laws organizing a grievance committee. It asked Council approval to the effect that such amendment was not inconsistent with the by-laws of the State Medical Society. The Council, without discussion, and on motion of Doctors Lokvam–McCarey, carried, approved such amendment.

18. Report of the Executive Committee

The Executive Committee reported (from its February 26, 1956 meeting) that:

a. It has reviewed the insurance program and bond of employees of the State Medical Society. It found that program to be adequate, and no formal action was deemed necessary.

b. It recommended rescission of previous Council action which, while approving the organization of Wisconsin Medical Assistants, imposed the condition that no financial assistance be given. The Executive Committee recommended that approval be continued, with authority to extend minimal expense reimbursement. This was approved on motion of Doctor Garrison, variously seconded, and carried.

c. It favored polling those physicians registering at the annual meeting, and those not attending, asking their reactions and reasons, with a subsequent report to be distributed to individual Councilors. This recommendation was accepted on motion of Doctors Fox–Kasten, carried.

19. Elections to Executive Committee

a. Because of the expiration of the Councilor term of Dr. A. J. McCarey, the Council was asked to elect a successor.

On motion of Doctors Ekblad–McCarey, carried, Dr. E. L. Bernhart was elected to succeed Doctor McCarey for a two-year term.

b. A successor was to be elected to fill the expired term on the Executive Committee of Dr. J. M. Bell.

On motion of Doctors Dessloch–Kasten, carried, Doctor Bell was elected to succeed himself on the Committee.

20. Resolutions Relating to the Transfer of Securities

The following resolutions were presented for Council action:

"WHEREAS, Section 6, Chapter VI of the By-laws of the State Medical Society of Wisconsin, a Corporation organized under the laws of Wisconsin, provides in part that the Council, the governing body of that Society, "through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds"; and

"WHEREAS, a portion of the funds of Wisconsin Physicians Service, a division of the said Society, has been invested in obligations of the government of the United States,

"Be it resolved, that any of the three members of the Committee on Auditing and Finance, or the treasurer of the said Society, shall have continuing authorization to assign and sell, or otherwise dispose of any and all United States securities, or securities with respect to which the Treasury Department acts as transfer agent, now or hereafter, which are registered in the name of or otherwise owned by this Society, and for the transfer of such obligations to appoint one or more attorneys-in-fact with authority in turn to appoint one or more substitutes.

"Be it further resolved, that any and all action as authorized above with respect to any such securities heretofore taken by the above named officers, or any of them, is hereby ratified."

The above resolution was approved on motion of Doctors Garrison–Fox, carried.

"Resolved, That N. A. Hill, M.D., Assistant Treasurer of the State Medical Society of Wisconsin, and Treasurer of Wisconsin Physicians Service, a Division of the State Medical Society of Wisconsin, is hereby authorized to assign and sell or otherwise dispose of the following described United States securities (see table below) with respect to which the Treasury Department acts as transfer agency, registered in the name of this corporation, and for such purpose to appoint one or more attorneys-in-fact with authority in turn to appoint one or more substitutes.

"And it is further resolved, That any and all action as authorized with respect to the above described securities, heretofore taken by the above named officers, is hereby ratified."

The resolution was approved on motion of Doctors Garrison–Fox, carried.

"Resolved, That any of the following officers of the State Medical Society of Wisconsin

Treasurer

or either Assistant Treasurer

shall be authorized to assign and sell or otherwise dispose of any and all United States securities, or securities with respect to which the

Title of Loan and Series or Issue Date	Denomination	Serial No.	Exact Inscription
U. S. Treasury Bonds (2¼%) Issue Date 11-15-45	$100,000	1739K	State Medical Society of Wisconsin, (A Corporation), Wisconsin Physicians Service Account
" " " " " " "	10,000	7200L	" " "
" " " " " " "	10,000	7201A	" " "
" " " " " " "	10,000	7202B	" " "
" " " " " " "	10,000	7203C	" " "
" " " " " " "	10,000	7204D	" " "
U. S. Treasury Bond (2¼%) Issue Date 6-1-45	$100,000	2618J	" " "

Treasury Department acts as transfer agency, now or hereafter registered in the name of or otherwise owned by this corporation, including those at any time owned by Wisconsin Physicians Service, a Division of the State Medical Society of Wisconsin, and for such purpose to appoint one or more attorneys-in-fact with authority in turn to appoint one or more substitutes.

"*And it is further resolved,* That any and all action as authorized above with respect to any such securities heretofore taken by the above-named officers is hereby ratified."

The resolution was approved on motion of Doctors Garrison–Heidner, carried.

21. Report of the Executive Committee

The Executive Committee, meeting on Saturday, April 28, 1956, reported as follows:

1. Candidates for Office of Coroner

A 1955 law prohibits a funeral director also serving as coroner from burying any person whose death he is required to investigate as coroner. Of the 71 coroners in Wisconsin, approximately 34 were funeral directors as of January 1, 1956.

The State Association of Funeral Directors suggests that there be a joint program to encourage physicians to run for these positions.

The Executive Committee recommends appropriate publicity in *The Wisconsin Medical Journal,* but feels that otherwise the problem is a local one to be resolved at local levels.

Approved on motion of Doctors Ekblad–Fox, carried.

2. Workmen's Compensation Panel

The Wisconsin Osteopathic Association has approached the Industrial Commission, claiming that its cooperation with the State Medical Society in providing industrial plants with compensation panels of eligible physicians is discriminatory and partisan. The state association asks the Medical Society to include them on the panels.

It is the recommendation of the Executive Committee that the osteopathic organization be informed that this project of the State Medical Society is of long standing, is at its own expense, and has been developed as a public service activity of the medical profession, and that it should be continued as such.

Approved on motion of Doctors Ekblad–Curran, carried.

3. Major Medical Insurance Policy Advertised as Including within Medical Services the Services of Chiropractors

A local insurance company has advertised in at least one Wisconsin paper its major medical insurance program and under the description of medical services announces benefits for chiropractic treatment.

Since chiropractic treatment is not "medical" and falls distinctly into the category of cult practice, the Executive Committee recommends to the Council that the secretary enter into conversations with the insurance company so that it may be somewhat enlightened in this particular field.

Approved on motion of Doctors Dessloch–Heidner, carried.

4. Principles of Medical Ethics

Drug Topics, April 16, 1956, page 76, carries a news item entitled "AMA Expected to Modify Code of Ethics so as to Eliminate Conflict with Pharmacy."

Since this information has not been conveyed to the medical profession to the best of the knowledge of the Executive Committee, it recommends that the secretary be given instructions to make inquiry into the matter and specifically as to what change is proposed by the pharmaceutical profession which it apparently expects the AMA to adopt.

Approved on motion of Doctors Dessloch–Heidner, carried.

5. Conference on Aging

The Executive Committee recommends that the Council forward to the House of Delegates, with its endorsement, a resolution pertaining to the Governor's Conference on the Aging Population.

Approved on motion of Doctors Bell–Heidner, carried.

6. Miscellaneous

The Committee reports that it is undertaking a review of the Provident Group Insurance Program, and with Council approval, authorizes the staff and legal counsel to make a study of the constitution and by-laws of the State Medical Society, that they may be consistent with the 1953 revisions of the corporate laws of the state. It asks that the Council extend a message of greetings to Dr. John W. Truitt, former member of the Council and a past president, who recently suffered illness in Florida.

Approved on motion of Doctor Bell, variously seconded and carried.

22. Commendation re Annual Meeting

Doctor Bernhart said he felt the Council owed a vote of thanks and commendation to the Council on Scientific Work and to Mr. Ragatz for the splendid program planned for the 1956 meeting, and to Mr. Thayer for his work in connection with the Delegates' Handbook. Doctor Fox made the motion, which was variously seconded and carried.

23. Adjournment

There being no further business the Council adjourned its meeting at 9:15 p.m.

C. H. CROWNHART
Secretary

Approved:

R. G. ARVESON, M.D.
Chairman of the Council

Minutes of the Council Meeting, Land O'Lakes July 28, 1956

1. Call to Order and Roll Call

The Council was called to order at 2:00 p.m., July 28, by R. G. Arveson, M.D., chairman. All voting members of the Council were present except Doctors Lokvam, Kasten, and Fox. Also present were Doctors Simenstad, president; Fons, speaker of the House; Witte, Stovall, and Griffith, A.M.A. delegates; Sullivan, chairman of the Committee on Public Policy; Neupert, state health officer; and Hirschboeck, Rice, Kindschi, Lindert, and Lemmer, members of the Council on Scientific Work. Staff members present were Messrs. Crownhart, Thayer, Ragatz, Doran, and LaBissoniere, Miss McGruer and Miss Pyre. Also present were consultants Donald E. Gill, C.P.A., and Robert B. Murphy, legal counsel.

The chairman introduced the new members of the Council elected in May: Doctors Leahy of Park Falls and Conley of Milwaukee.

2. New Business

Doctor Ekblad, Superior, asked that the Council and the staff take under consideration ways and means to provide further time for both study and action as to matters on the agenda. The chairman pointed out that he felt matters could be condensed more than they are, but emphasized also that it is important that councilors be informed so that their action can be carefully taken.

3. Recommendations of the Committee on Grievances

After discussion, and on motion of Doctors Bell–Heidner, unanimously carried, the following recommendation of the Grievance Committee was adopted:

> The State Medical Society has been approached as to the propriety of the use of certain space in the classified section of a telephone directory.
>
> It is recommended that there be no use of the classified section of a telephone directory in any manner not approved by the local county medical society involved.
>
> When use of the classified section is contemplated outside of the county medical society area of those intending such action, the approval of the county medical society thus involved must be obtained.

After further discussion, and on motion of Doctors Conway–Carlson, the following additional recommendation of the Grievance Committee was approved:

> The position of the State Medical Society relative to newspaper advertisement or card or announcements as to the availability of vaccine against poliomyelitis in a particular doctor's office, even for his own patients, is of questionable ethics and can be both misleading and confusing to the public.

4. State Medical Journal Advertising Bureau, Inc.

The secretary explained that for many years the American Medical Association had provided state medical journals with the services of a department in securing ethical advertising of those products deemed acceptable for Journal advertising. Within the past several months this bureau has been created as a separate corporation under direct control of the various medical journals participating in its benefits. The new bureau is no longer associated, physically or by control, with the American Medical Association. The new bureau has proposed to the State Medical Society of Wisconsin that it become the official designated advertising soliciting agent for Wisconsin. Legal counsel of the Society has reviewed the contract and finds it acceptable.

> On motion of Doctors Bell–Garrison, carried, the secretary was authorized to execute such contract.

5. Separation of Brown-Kewaunee-Door Counties Medical Society

The secretary reported the wishes of this society to separate into those of Brown and of Kewaunee–Door. Under the constitution and by-laws, such action must first be approved by the Council and then by the House of Delegates, acting upon recommendation of the Council.

After discussion by Doctors Bell, Carlson, Heidner, and others, during which it was pointed out that the concentration of physicians was in Brown County, and it was in that area where meetings are held, making it difficult for physicians in the other two counties to attend, the Council voted favorably on the request, on motion of Doctors Bell–Dessloch, and directed that its action be reported to the House of Delegates.

6. Recommendations of Commission on State Departments

a. **Safety Belt Legislation.** The Commission recommended that the Society support legislation under which the Motor Vehicle Department would establish standards as to the quality and installation of safety belts in automobiles. After discussion by

Doctors Witte, Sullivan, Bernhart, and others, and on motion of Doctors Bernhart–Hill, carried, this recommendation was approved.

b. Epileptic Review Board. The secretary reported that under the laws relating to persons with epilepsy and their drivers' licenses, a driver's license limited to six months is granted, upon recommendation of a medical review board of two physicians. The board considers, among other things, reports of attending physicians as to the condition of the driver and whether he is under control by medication. The Commission asked that the review board be increased from two to five members, and that such a license may be issued upon affirmative vote of any two of such five-member board.

There was extensive discussion by Doctors Dessloch, Heidner, Conway, Leahy, Bernhart, and others, following which, upon motion of Doctors Hill–Bernhart, carried, the proposed legislation was approved.

At the request and motion of Doctors Conway–Heidner, carried, the entire subject of the status of the epileptic patient under various laws of the state is to be reviewed at a future meeting of the Council.

c. Determination of Total Disability. It was reported by the secretary that changes in the OASI law, and impending changes in social security laws, indicated the necessity of informing the physicians of the state as to the new requirements and the standards that are being imposed. There was discussion by a number of those present, following which these motions were put:

> . . . by Doctors Heidner–Bernhart, carried, that there be prepared a special article on this subject, to be published in *The Wisconsin Medical Journal*.
>
> . . . by Doctors Galasinski–Ekblad, carried, that the Society study the development of a voluntary medical review board, and the operation of a medical review board as may exist by statute.

d. Maladjusted Child and Proposed Legislation. The Commission on State Departments received information to the effect that the Bureau of Handicapped Children, State Department of Public Instruction, would seek funds in 1957 to analyze the problem of the severely disturbed children in public schools, to locate these children, and to establish some type of preventive or curative program to guard against fixed psychoses. The secretary reported that this proposed program raised certain policy questions, it being debatable as to which state department should be most logically concerned with this program of public health. Some indication had been received that the State Department of Public Welfare was also concerned.

> On motion of Doctors Conway–Bell, carried, the matter was laid over to an ensuing meeting, before which more information could be obtained.

e. A.M.A. Section Speaker on Ophthalmologic-Optometric Relations. Because of current stated positions of optometrists as to those entitled or to be entitled to do refractions, the Public Relations Committee of the A.M.A. Section on Ophthalmology asked state medical associations to consider having a special speaker on the subject at their annual meetings. On motion of Doctors Ekblad–Bell, carried, this request was referred to the Council on Scientific Work without recommendation.

f. Wisconsin's Public Health Programs. Doctor Neupert, state health officer, elaborated upon a report earlier made to the Commission on State Departments which urged Council action. The burden of Doctor Neupert's report was that decreased federal funds and lack of adequate state financial support were seriously affecting the ability of his department to carry out its duties. There is also insufficient personnel. Following a 45-minute discussion of the subject, it was agreed that the staff, in cooperation with Doctor Neupert, should prepare a detailed report for later consideration.

7. F. X. Pomainville, M.D., Wisconsin Rapids

Doctor Garrison drew the attention of the Council to this distinguished member of the profession who was to attain his eighty-fifth birthday on August 11, 1956. Upon his motion, seconded by Doctor Dessloch, the following resolution was unanimously adopted:

> COUNCIL CITATION OF MERIT
> Extended to
> F. X. POMAINVILLE, M.D.
> of
> Wisconsin Rapids
>
> On the Occasion of his Eighty-Fifth Birthday
> August 11, 1956
>
> WHEREAS, This good friend of the people, affectionately referred to as "Doctor F. X.," has served his native community throughout his entire professional career, and
>
> WHEREAS, Since graduation from Rush Medical College in 1899, he has been engaged in practice in Wisconsin Rapids, being born in that community when the east side was Grand Rapids and the west side was Centralia, Dr. F. X. Pomainville has served his fellow citizens in many civic positions, including membership on school boards and as mayor, and
>
> WHEREAS, In his devotion to the health of mankind, he has accepted his responsibilities in manifold ways, including serving his community as its health officer and the Wood County Medical Society as its president and its secretary, and

WHEREAS, His professional career includes service to his country in the Medical Corps of the Armed Forces in World War I, being honorably discharged with the rank of major; now, therefore be it

Resolved, By the Council in meeting assembled July 28, 1956, that this resolution be spread upon the records of its meeting as an official CITATION OF MERIT to FRANK XAVIER POMAINVILLE, M.D., a physician who has been a leader among men and an encouraging example to all; and be it further

Resolved, That a copy of this resolution, duly attested, be presented to Doctor Pomainville with the best wishes and congratulations of the State Medical Society of Wisconsin, of which he has been, since 1949, a life member.

8. Report of the Committee on Grievances

The substance of this report outlined procedures and policies with reference to studying such matters of public relations as physicians' office hours, etc. On motion of Doctors Carlson–Heidner, carried, the report was approved.

9. Report of the Council on Scientific Work

Members of this Council were introduced by Chairman Arveson, following which Doctor Rice presented the following (summarized) report:

That the deans of the two medical schools in Wisconsin and the medical editor of *The Wisconsin Medical Journal* be regular voting members of the Council on Scientific Work, and that the by-laws be amended to that effect.

That regular guests at meetings of the Council will be those physicians responsible for the postgraduate teaching programs at the two medical schools.

That pending further study of the instruction of the House of Delegates relative to integration of postgraduate teaching, the Council develop closer liaison through more frequent meetings.

That specialty programs, and that of the Wisconsin Academy of General Practice, be continued as an integral part of the Annual Meeting program.

That color television be employed as part of the 1957 program.

Following discussion, and upon motion of Doctors Galasinski–Carlson, carried, the recommendations and report of the Council on Scientific Work were unanimously approved.

The secretary then reported on attendance at the Annual Meeting, with each Councilor being supplied with lists, by counties, of those registering and those not in attendance in 1956. It was pointed out that many counties had excellent registration; *i.e.* Fond du Lac, Outagamie, and Sheboygan.

The next matter was further consideration of the subject of coordination of post graduate medical education in Wisconsin. The secretary reported (summarized) that this matter had been brought before the House of Delegates in May, 1956, by Doctor Morton, then chairman of the Council on Scientific Work. The gist of the suggestion was that the State Medical Society not only undertake coordination of scientific programs suggested by medical and non-medical organizations, but in addition evaluate them in light of current needs and undertake their promotion as a direct responsibility. The House had acted favorably, and the staff had undertaken preliminary studies with the Wisconsin Division of the American Cancer Society, the Wisconsin Heart Association, and others.

The secretary stated that he was concerned over the financing of the program, it being his observation that when such projects are actually under way, they become bigger and more involved than initially contemplated. He estimated that the total costs involved, including promotional, would ultimately be in the neighborhood of $15,000 annually. He stated that he was concerned that another project not be initiated until its financing could be thoroughly understood. Doctor Bernhart stated that he felt this project must be undertaken at an early date, and Doctor Conway related personal experiences indicating its necessity.

After considerable discussion, it was moved by Doctors Bernhart–Hill, carried, that the proposal be referred to the Audit and Budget Committee for subsequent report to the Council.

On motion of Doctors Dessloch–Garrison, carried, the Council voted its unanimous commendation of the report of the Council on Scientific Work as presented at this meeting.

10. Report of Council on Medical Service and Committee on Hospital Relations (presented by the secretary)

These two groups have met twice in joint session to determine the advisability of a survey in Wisconsin relative to such problems as may exist between hospital administration and physician staffs. Each member of the two groups has by assignment attempted to ascertain the relationship insofar as his own hospital is concerned.

There is a general opinion that in many areas of the state there are problems which should be resolved through joint conferences or other mechanisms, but that to determine the extent and character of such problems, an extensive survey is indicated, possibly through the media of questionnaires directed to the chiefs of staff, hospital administrators. members of the House of Delegates, and others.

The matters to be surveyed would include staff organization, liaison between staff and administration and between staff administration and board of

trustees. Also included would be relationship of the several specialties, use of interns in providing emergency or out-patient care, and similar matters.

The matter is referred to the Council by the Committee on Hospital Relations and Council on Medical Service for further discussion and exploration, and analyses as to staff participation and cost.

After discussion of this and related subjects, it was moved by Doctors Bernhart–Garrison, carried, that the staff carry on limited studies of these matters, and that the subject be reviewed by the Council on Medical Service and the Committee on Hospital Relations for periodic reports to the Council.

* * *

Mr. Thayer then presented a further report of the Council on Medical Service which stated that it had reviewed in detail the report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals (Stover Report) adopted by the A.M.A. House of Delegates in June, 1956. This comprehensive report reviewed the history of the Joint Commission and gave a number of questions concerning its activities and the committee's replies to them.

It was the recommendation of the Council on Medical Service that reprints should be obtained and distributed to all county medical society secretaries and the chiefs of staff of all Wisconsin hospitals.

On motion of Doctors Dessloch–Heidner, this recommendation was accepted.

11. Resolution re General Practice Residency Training

The following resolution was presented for Council consideration by R. R. Richards, M.D., Eau Claire, chairman of the General Practice Residency Committee:

Inasmuch as Luther Hospital has established an approved general practice residency program which is hoped will lead ultimately to an increase in the number of general practitioners in this area, we believe that the regulations concerning licensure in the State of Wisconsin should be modified so that graduates of approved American medical schools with one year internship may be permitted to do a year of residency training in a general practice training program without being required to take the state board examination for medical licensure.

Many of the applicants for the training program are from other states and at time of application do not know whether they wish to permanently reside in the State of Wisconsin. Few of the states having hospitals offering general practice residency have as rigid rules for licensure as the State of Wisconsin and, therefore, we compete unsuccessfully with hospitals in those states for the services of prospective residents. Since many of them then settle in the general area in which they have had their residency, we believe this policy works to the detriment of the practice of medicine in the State of Wisconsin. It certainly is a hardship to expect men coming to this hospital for one year on a limited stipend to spend three days and a sizable amount of money taking the state medical examination when they are not at all sure they wish to remain in the State of Wisconsin. Therefore, we believe that residents entering the approved general practice residency program should be given the same consideration as they are in other states and not required to obtain a license during their brief stay as residents.

The secretary felt that this resolution could not be effected without a change in the Wisconsin laws, which require residents to have a license as a prerequisite to training. The secretary felt that the matter referred primarily to Fulbright scholars, but Doctor Bernhart felt that the problem in Eau Claire related primarily to graduates of approved schools who did not wish to incur the expense of licensure in Wisconsin for one year's training. Mr. Crownhart said, however, that Wisconsin has provision for educational permits which, under the law, are not limited in availability only to the foreign-trained physician; the policy of the State Board of Medical Examiners is to so limit at the present time. Doctor Conway inquired as to cost of full licensure for taking the examination and said that he felt if the hospital wanted the individual enough, it could pay that cost itself.

On motion made by Doctors Dessloch–Bell/Bernhart, carried, the resolution was referred to the Committee on Public Policy for study.

12. Home Town Care Program—Veterans Administration

The secretary reported developments to date to the effect that the Veterans Administration proposes cancellation of the intermediary program as now administered by the Society and substitution therefor of a program administered in all essential respects by the VA, but with the Society distributing payments, settling areas of difference, and establishing appropriate schedules of benefits. He expressed his opinion that the material from the Veterans Administration had not been received in sufficient time to permit mature consideration, and that the matter should be held over until a subsequent meeting of the Council.

On motion of Doctors Dessloch–Ekblad, carried, the secretary's suggestion was approved.

13. Report of Executive Committee

The following report was approved:

a. The Executive Committee nominates the Honorable Oscar Rennebohm and the Honorable

A. Matt Werner to be nonmedical trustees in connection with the activities of the S.M.S. Foundation.

Both of these outstanding men are currently trustees of the Student Loan Fund, and the committee suggests to the Council the wisdom of having them serve in the capacity of trustees of the S.M.S. Foundation.

Under the structure of the Foundation, the Council may elect as many as 10 nonmedical members in addition to the approximately 75 physician trustees.

On motion duly made, seconded and carried, the Council unanimously elected Messrs. Rennebohm and Werner nonmedical trustees of the S.M.S. Foundation.

b. The Executive Committee reports that it concurs in the recommendation of the secretary that *The Wisconsin Medical Journal* be placed on an accurate cost accounting basis.

This recommendation was approved on motion of Doctors Galasinski–Carlson, carried.

c. The Executive Committee urges the delegates to the American Medical Association to take action looking to the revision of section 7 of the *proposed* Principles of Medical Ethics which are to come officially before the House of Delegates of the A.M.A. at the Seattle, November, 1956, meeting.

Approval of the recommendation was on motion of Doctors Ekblad–Bernhart, carried.

d. The committee conferred with President Simenstad with regard to two existing committee vacancies. President Simenstad appoints E. C. Howell, M.D., Fennimore, to the Committee on Cancer to fill a vacancy caused by the resignation of one of its members, and Arthur J. McCarey, M.D., Green Bay, to the Committee on Hospital Relations, to fill a vacancy caused by the death of one of its members.

These appointments were approved on motion of Doctors Galasinski–Hill, carried.

14. Report of the Secretary

The secretary reported that an invitation had been extended Doctor and Mrs. George F. Lull to meet with the Council at its July, 1957, meeting, which report was accepted with applause. In addition, the secretary reported that a representative of the Provident Life & Accident Insurance Company, Chattanooga, Tennessee, would be housed without charge in the State Society building for the ensuing six months. The assignment of this individual, Mr. Thomas Henry, would be to enroll physicians to the point necessary to keep the Society's percentage requirements in effect with respect to its group disability program. The secretary also announced that it was the staff's plan to implement the Foundation with part-time executive assistance beginning January, 1957.

* * * * *

The meeting recessed at 5:30 p.m., and was reconvened at 8:00 p.m.

* * * * *

15. Resignation of H. E. Kasten, M.D., Councilor, Third District

Doctor Kasten's resignation was placed before the Council. It was stated by him that since he has been elected "president-elect of the State Medical Society, I will be privileged to attend the meetings of the Council. I have enjoyed my association with my fellow Councilors and consider it to have been one of the greatest privileges that can be accorded to a physician. My experiences with this very fine group will constitute a cherished memory forever."

On motion of Doctors Hill–Bell, the resignation of Doctor Kasten was accepted, with an expression of appreciation for the fine service he has given the State Medical Society as a Councilor.

16. Election of J. H. Houghton, M.D., as Councilor

On motion of Doctors Hill–Garrison, carried, Doctor Houghton, Wisconsin Dells, was elected Councilor to fill the remaining portion of Doctor Kasten's term of office.

17. Resolution Concerning the Presidency of the American Medical Association

On motion of Doctors Bell–Dessloch, carried, the following resolution was adopted by acclamation:

WHEREAS, The presidency of the American Medical Association is the highest honor within the gift of physicians to a colleague and is traditionally bestowed upon a member whose career has been marked by long and devoted professional and public service; and

WHEREAS, Gunnar Gundersen, M.D., of La Crosse, Wisconsin, a member of a family of eminent physicians, has served the State Medical Society of Wisconsin as speaker of its House of Delegates, as its president, as a member of the founding Board of Directors of Blue Shield of Wisconsin, and as a member of many other committees concerned with the development of its scientific and economic policies; and

WHEREAS, In other capacities of citizenship, he has contributed a public service through membership on the Board of Regents of the University of Wisconsin and as a member and president of the Wisconsin State Board of Health; and

WHEREAS, Doctor Gundersen has served successively as delegate to the American Medical Association from Wisconsin, chairman of the Joint Commission on Accreditation of Hospitals during its two formative years, member of the Board of Trustees of the American Medical Association, chairman of its Executive Committee, and now in his second term on the Board as its chairman; and in addition, during the past three years, Doctor Gundersen has represented the American Medical Association on the Council of the World Medical Association; and

WHEREAS, This distinguished career amply attests to his qualifications to represent American medicine as president of the American Medical Association; now, therefore, be it

Resolved, That the Council of the State Medical Society of Wisconsin, assembled at Land O'Lakes, Wisconsin, on July 28, 1956, requests the Wisconsin delegation to present Gunnar Gundersen, M.D., of La Crosse, Wisconsin, to the House of Delegates of the American Medical Association for election to the office of president-elect of the A.M.A. at its annual session in New York in June, 1957; and be it further

Resolved, That copies of this resolution be distributed to all members of the House of Delegates of the American Medical Association.

18. Dependents' Medical Care—Public Law 569, 84th Congress, Second Session

The secretary briefly outlined the background of this legislation, referring to a bulletin sent by him to the Council in December, 1955. This was followed by a bulletin in June, 1956, reporting as to a special conference in Chicago early that month in which Department of Defense officials and others met with representatives of the American Medical Association, particularly members of the Board of Trustees, the Council on Medical Service, and members of one of the reference committees of the House of Delegates.

In this special bulletin, the secretary had stated his recommendation that a program of the home town care type should be developed, with Wisconsin accepting the full service concept and entering into a negotiated fee schedule.

The secretary then told of a special meeting of all state medical associations being held during the course of this weekend on call of the American Medical Association. He had asked Doctor Casper of Milwaukee; Mr. W. C. White, Jr., assistant secretary; Mr. J. F. Burke, assistant to Mr. Thayer; Mr. S. E. Gavin, Jr., legal counsel; and Mr. Carl Tiffany, consulting actuary, to attend on behalf of Wisconsin. Arrangements had been made to receive and record a telephone report of the meeting so that the Council could then take appropriate action.

The recorded telephone report (approximately one hour in length) was then played to those present at the Council meeting, the Councilors and officers, and some guests. Following this report there was discussion, at the conclusion of which Doctor Dessloch stated: "The Council has the obligation, and must approve the action of the staff up to now, and in the future, in behalf of this program. We can't let down and have to urge the staff to continue to watch it daily . . . The only thing we need to do at the moment is to approve the staff's activity in this problem of dependent care for the military, and urge them to continue in the same vein which they have in the past. I so move."

The motion was seconded by Doctor Hill, and unanimously carried.

19. Adjournment

There being no further business, the Council adjourned at 10:00 p.m., July 28, 1956.

C. H. CROWNHART
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

ILLINOIS CONGRESS ON MATERNAL CARE

St. Nicholas Hotel, Springfield, February 13–14, 1957

Twenty Round Tables: 3:15 and 4:30 p.m., Wednesday, February 13
10:15 and 11:30 a.m., Thursday, February 14

Topics: Adoption, Anemias of Pregnancy, Changing Indications for Cesarean Section, Common Emergencies in the Newborn, Community Organization for Obstetric Service for Military Dependents, Detection and Management of Erythroblastosis, Diabetes in Pregnancy, Ectopic Pregnancy, Emotional Aspects of Pregnancy, Hypnosis as an Adjunct in Obstetrics and Gynecology, Induction of Labor, Management of Spontaneous Abortion, New Concepts in Ante- and Postpartum Care, Obstetric Analgesia and Anesthesia, Parent Education—Whose Responsibility, Recognition and Control of Epidemic Newborn Diarrhea, Problems of a Small Community Hospital, Value of Accurate Obstetric Records in Maternal and Infant Mortality Studies, Unmarried Parenthood, Weight Control During Pregnancy.

Twenty Breakfast Conferences: 1 hour, 15 minutes each—7:30 a.m., Thursday, February 14. A charge of $1.50 will include breakfast. Same topics discussed as at round tables.

For further information, write: **Illinois Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.**

Minutes of the Council Meeting, Manitowish September 7-8, 1956

The Council and Officers, members of the Commission on Medical Care Plans, guests and staff first met in joint session on Friday, September 8, with Chairman of the Council, R. G. Arveson, Frederic, presiding. Co-chairman was E. M. Dessloch, Prairie du Chien, chairman of the Commission on Medical Care Plans.

The purpose of the meeting was explained as carrying out the directive of the Council for a special meeting at which the various facets and procedures of the operation of medical care plans might be explained. This portion of the proceedings is recorded in the minutes of the Commission.

Following this presentation, and on Saturday, September 8, 1956, the Council met in formal session, Chairman Arveson presiding.

1. Call to Order and Roll Call

Chairman Arveson called the meeting to order at 3:00 p.m. The roll call showed all voting members present except Councilor Fox.

Officers present were Doctors Simenstad, president; Kasten, president-elect; and Doctors Witte, Griffith, Stovall and Gavin, delegates to the American Medical Association.

Commissioners present were Doctors Supernaw, Reznichek, Sprague, Moore, Hilker, Wolf, Goldstein, Doege, Foregger, McCarey and Casper. (Commissioners present who were included in the Council roll call were Doctors Dessloch, Hill, Garrison and Carlson.)

Guests present were Dr. Gunnar Gundersen, Chairman of the Board of Trustees, A.M.A.; Dr. C. N. Neupert, state health officer; Dr. William Kruel, Racine; Dr. Thomas Alphin, Dr. William Kennard and Mr. F. W. Kuehl, of the Washington A.M.A. office.

Staff and consultants present were Messrs. Crownhart, Thayer, White, Doran, LaBissoniere, Hoops, Doege, Burke, Koenig, and Misses McGruer, Pyre, Cordts and Moran; R. C. Parkin, M.D., medical consultant; D. E. Gill, the Society's C. P. A.; C. A. Tiffany, the Society's actuary; and R. B. Murphy and S. E. Gavin, Jr., legal counsel.

2. General Comments

Doctor Arveson stated that he felt the meeting had been successful and informative, and showed hard work in its preparation. Doctor Conway stated that it was a fine demonstration and he felt that he and others had learned a great deal.

> On motion of Doctors Ekblad–Galasinski, carried, the Council extended its appreciation to the Commission on Medical Care Plans for the program.

3. Resolution Implementing Dependents Medical Care Plan in Wisconsin

The secretary stated that on recommendation of the Executive Committees of the Commission and of the Council, the following resolution was before the Council:

> "WHEREAS, The Council of the State Medical Society of Wisconsin, at a meeting held July 28, 1956, authorized the secretary and staff to enter into negotiations on behalf of the Society with the United States Government for the rendition of medical care to dependents of members of the uniformed services, and other eligible persons, situated in Wisconsin, such action being considered advisable because of the federal enactment of Public Law 569, 1956, which became effective in June, 1956, known as the "Dependents' Medical Care Act," and
>
> "WHEREAS, The dependents of members of the uniformed services are an important segment of the general civilian population, and
>
> "WHEREAS, It is recognized by this Society, as the operator of various medical care plans, that it is important to investigate feasible methods of covering these and other segments of the population for which insurance, prepayment or other health care devices have not thus far been developed on any widespread basis, and to study methods of applying recognized insurance principles to such segments, and
>
> "WHEREAS, It is further recognized that this and other medical societies, acting through all instrumentalities and facilities at their commands, should take the initiative in developing mechanisms for providing for the health care of all segments of the population, and it is appreciated that this will call for an increasing amount of research and experimentation; be it, therefore,
>
> "*Resolved*, That the Council of the State Medical Society of Wisconsin commit to its Commission on Medical Care Plans the matter of dependents' medical care, with the specific instruction that the Commission proceed with the negotiation of an appropriate fee schedule with the federal government for the care of the dependents of members of the uniformed services; that it work out the mechanics of payment of claims for such personnel; that it also devise feasible and efficient means for acting as fiscal agent of medical societies situated in adjoining states which may invite this Society to act in such capacity; and be it further

"*Resolved*, That the Commission be authorized to use such personnel, and to advance or expend such funds as may be necessary, to conduct such negotiations, set up appropriate administrative procedures, and engage in research into the feasibility of serving the dependents of members of the uniformed services on an insurance basis, or if serving them through a predetermined fee schedule, and on an individual procedure contract basis, as is proposed in the present law, and in the contemplated arrangements with the federal government; and be it further

"*Resolved*, That the Commission be requested to report significant developments as rapidly as practical after their occurrence, and that it continue to report its experience, should such negotiations be concluded, at quarterly or other frequent intervals; and be it finally

"*Resolved*, That this program be uniquely identified in order to avoid any impression or misunderstanding that this program is a part of Blue Shield, the Wisconsin Plan, or the Veterans Medical Service Agency.

On motion of Doctors Hill–Ekblad, carried, the resolution was adopted.

4. Discussion Concerning Proposed Schedule of Benefits

Doctor Bernhart stated, for the information of the Council, that earlier in the meeting he had a long distance telephone conversation with Dr. Paul Mason, Sheboygan, who was at the time in a Chicago meeting of the national Blue Shield Commission. Doctor Mason reported that it was generally understood among everyone concerned that the fee schedule to be negotiated would be unpublished; that payment will be the usual fee of the area in which the service is performed, but not beyond the maximum negotiated. It was Doctor Bernhart's impression that the program would run much as does Wisconsin's effort in the so-called "Racine plan."

5. Resolution Empowering Wisconsin to Act as Agent for Other States

The secretary stated that North Dakota, while desirous of entering into its own contract, supervising claim settlement and negotiating its own schedule, lacked the machinery to handle the mechanisms of the plan. It desired the cooperation of Wisconsin. In light of this and other facts, the following resolution was presented the Council:

"WHEREAS, Public Law 569, 1956, 84th Congress, permits the United States Government to contract with state medical societies for the rendition of medical care to certain dependents of members of the uniformed services, and

"WHEREAS, such state medical societies may designate fiscal agents on their behalf, and

"WHEREAS, there may be some state medical societies in the central states area which may desire to utilize the mechanical and other procedural facilities of Wisconsin, but negotiate their own contract with the United States Government, including a schedule of benefits satisfactory to a particular state, and retain field service and claim adjustments; therefore, be it

"*Resolved*, that the Commission on Medical Care Plans acting under authority previously granted as to DMCP (Dependents Medical Care Program) in Wisconsin, have the further authority of entering into arrangements whereby Wisconsin would act as fiscal agent for another state medical society or societies."

On motion of Doctors Dessloch–Bell, carried, the resolution was unanimously adopted.

6. Change in Commission Name Authorized

The Commission asked that its name be changed from Commission on Prepaid Plans to "Commission on Medical Care Plans," inasmuch as DMCP is not a prepaid program.

On motion of Doctors Bernhart–Garrison, carried, the recommendation was approved.

7. Authorization to SMS Foundation to Study Operation of DMCP

The secretary reported that in his estimation, if Wisconsin is able to negotiate a fee schedule for DMCP under which it will be generally possible to reimburse physicians based upon community level of charges, it will be due to the foresight and the work of the Commission and the Council in Wisconsin and no one else. He then stated that "all the know-how and ingenuity is not confined within the walls of the State Medical Society." It is proposed that there "be committed to the Foundation of the State Medical Society authority to conduct studies of this program as it develops and that the Foundation invite private insurance carriers or any other interested group to participate in such studies, in the thought that there still remains an area where perhaps prepayment can be brought into the picture, and where (it may be possible) to eliminate a straight postpayment program."

On motion of Doctors Garrison–Dessloch, carried, this recommendation was approved and such authority granted the Foundation.

8. Directory of Certain Health Facilities in Wisconsin

The Executive Committee of the Council reported that it had received a request from a public health agency in Wisconsin asking that approval be given to a proposed directory of physical facilities in its particular field of interest, including a listing of physicians belonging to a particular association.

The Executive Committee reported to the Council that it considered such a listing of physicians, for various reasons, as not feasible and, in any event, of doubtful ethical standards.

On motion of Doctors Heidner–Conley, carried, the report was accepted.

9. Hill-Burton Questionnaire

Secretary Crownhart reported that the Society was in receipt of a questionnaire from the Council on Medical Service of the American Medical Association asking reactions and questions concerning operations of the Hill–Burton hospital construction plan. The Executive Committee recommended that general authority be granted him to answer the questions, chiefly to the point that its operation has been acceptable to date but that a general re-appraisal is now indicated.

On motion duly made, seconded and passed, the secretary was so authorized.

10. Provident Insurance Program

The secretary was instructed to outline steps to stabilize enrollment and assure continuity of the program. Mr. Crownhart stated that for several months Mr. Henry, of the Provident Insurance Company, would be stationed in the Madison offices and would undertake an active enrollment program.

On motion of Doctors Bell–Galasinski, carried, these actions were approved.

11. Adjournment

There being no further business, the meeting adjourned at 3:30 p.m.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council

Minutes of the Council Meeting, Madison October 27, 1956

1. Call to Order and Roll Call

Chairman R. G. Arveson called the meeting to order at 2:00 p.m., in Madison.

All voting members of the Council were present except Doctors Bell, Garrison, Galasinski, Conley and Leahy. Doctor Heidner arrived late. Officers present were Doctors Simenstad, president; Kasten, president-elect; Witte and Stovall, AMA delegates; and Weston, treasurer.

Guests representing the Medical Society of Milwaukee County were Doctors Egan, member of the board, and Fons, president (also Speaker of the House); Mr. Kelley, executive secretary; and Mr. Johnson, attorney for the county society.

Staff and consultants present were Secretary Crownhart; Assistant Secretaries White, Thayer and Ragatz; Mr. Doran; Mr. Koenig; Mr. LaBissoniere; Misses McGruer, Pyre and Moran; Messrs. D. E. Gill and J. B. White, the Society's certified public accountants; Messrs. R. B. Murphy and S. E. Gavin, legal counsel; and Mr. Carl Tiffany, consulting actuary.

Guests present were Doctor Casper, Milwaukee, chairman of the DMCP committee of the Commission on Medical Care Plans, and members of that committee, Doctors Reznichek and McCarey. Dr. J. S. Supernaw, Madison, a member of the negotiating team appointed to meet with government officials, was also present.

2. Explanatory Background

DMCP (Dependents Medical Care Program) had been both informally and formally presented to the Council on prior occasions. See minutes of the July 29 and September 8, 1956 Council meetings.

In substance the program called for governmental reimbursement for defined care of dependents of men in military service, pursuant to contract and associated fee schedule. On October 15, 1956, the secretary received notification from Major General Robinson that Wisconsin's contract and fee schedule would be negotiated October 29, 1956. This information was the same day transmitted to Councilors, Officers, members of the Commission on Medical Care Plans, and ten copies of that bulletin and enclosures were sent to Mr. Kelley, executive secretary of the Medical Society of Milwaukee County.

On October 21 and 23 final work was completed by Wisconsin on a proposed schedule of benefits. On October 22 representatives from Wisconsin met in St. Paul and Minneapolis relative to contract terminology. On October 23 they left to observe first negotiations with other states in Washington, D.C.

On Wednesday, October 24, the secretary received informal advice to the effect that the previous evening the Board of Directors of the Medical Society of Milwaukee County expressed a desire to participate in the negotiations scheduled for October 29, and the information was of such character as to indicate to the secretary that Milwaukee County was not in agreement with the schedule being proposed by Wisconsin, and desired separate administration of the program in its county. Acting upon this information, and with approval of the chairman of the Council, a call for a meeting of the Council was telegraphed via night letter, on October 24th.

3. Resolution of the Medical Society of Milwaukee County

The actual resolution of the county society was received in the State Society's offices on Friday, October 26, and is as follows:

"Inasmuch as Milwaukee County constitutes the largest metropolitan area in Wisconsin, and

"WHEREAS Public Law 569 as enacted greatly affects the practice of medicine, and

"WHEREAS the Board of Directors of The Medical Society of Milwaukee County feels their responsibility to the membership of The Medical Society of Milwaukee County, and

"WHEREAS it has been definitely indicated that Government intends to negotiate separately with metropolitan and rural areas; therefore be it

"*Resolved that*:

"1. The Medical Society of Milwaukee County wishes to participate with the State Medical Society of Wisconsin in all negotiations with the Government in connection with the fee schedule, contract, and implementation of the directives pursuant to Public Law 569 providing for the care of dependents of military personnel,

"2. The Medical Society of Milwaukee County wishes to reserve the right to administer the program for medical care for military dependents in Milwaukee County.

"In view of this resolution, the Board of Directors offers the services of one or more physicians appointed by the President of The Medical Society of Milwaukee County and Mr. Kelley, Executive Secretary, and Mr. Luthmers, Assistant Executive Secretary, to join in the Washington negotiations."

After presentation of the problem by various councilors and officers, the chairman appointed a special committee composed of Doctors Bernhart and Conway, Milwaukee; Fox, La Crosse; and Dessloch, Prairie du Chien; to review the subject and to present recommendations to the Council.

Following separate deliberations by the committee, Doctor Deesloch reported its recommendations as follows:

"*Resolved*, that the negotiations under consideration refer only to the Dependents Medical Care Act and shall in no way be construed as granting authority for any future negotiation with the federal government for special groups."

Doctor Dessloch moved the adoption of the resolution, it was seconded by Doctor Ekblad and the motion carried.

Doctor Dessloch then stated the consensus of the committee was that the negotiating committee would continue as named: Doctor Casper, Milwaukee; Doctor Supernaw, Madison; Messrs. W. C. White, Jr., assistant secretary, John B. White, CPA, and S. E. Gavin, Jr., legal counsel.

Doctor Fons then requested that the action of the Council be transmitted to the Board of Directors of the Medical Society of Milwaukee County as the answer to the resolution of that Board.

4. Adjournment

There being no further business the special meeting of the Council adjourned at 4:20 p.m.

C. H. CROWNHART
Secretary

Approved:

R. G. ARVESON, M. D.
Chairman of the Council

ERRATA

Our attention has been called to a typographical error in the August, 1956, issue of the Journal. Under the head, "Report of the State Advisory Committee on Poliomyelitis Vaccine by Doctor Salk," page 886, the first sentence in the second paragraph reads, "Following the announcement of the unsuccessful field trials conducted by the National Foundation for Infantile Paralysis in the field of vaccination against the disease in 1954, the President of the United States called a conference of leaders in the public health field, virologists, educators, doctors of medicine, and prominent laymen throughout the country to discuss the best methods of handling a very difficult situation." The sixth word in the sentence should, of course, have been "successful" rather than "unsuccessful."

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISC N

Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

"Third Party Agreements"*

"Some years ago it was a disturbing thought to many physicians and continues to be to some physicians today that we must have third parties with their fee schedules, but we cannot honestly face the facts without some disturbing reaction. The facts are that third parties are with us and their impact upon medical practice is great and will increase. The average working person in this country will have the bulk of his medical costs insured, and the medical services covered by the contracts will have to be paid for in full without any extra charge by the physician or surgeon . . .

"Fee schedules will have to give physicians and surgeons adequate remuneration for their services, and the schedules will have to present correct relationship between the services rendered in the various special fields. The fees allowed in the schedule must become the customary fees in the area for all except those who are well above the average income for the community. These fee schedules must be devised by the medical societies themselves or by the Blue Shield plans sponsored by the medical societies."—THOMAS J. DANAHER, M.D., *President, Connecticut Medical Service, Inc.*

How Far Can Coverage Be Expanded?

Voluntary health insurance coverage is expanding "too slowly," George Bugbee recently warned the American Hospital Association. Bugbee is president of the Health Information Foundation and former executive secretary of the hospital association.

"Families with voluntary health insurance and who incur medical bills of over $500 a year have only 25 per cent of the costs covered by their insurance, on the average," he said.

"No provision is made for home and office medical care which makes up approximately another 20 per cent of all medical care and about two-thirds of all fees to physicians," Bugbee declared. He felt there should also be provision for the cost of drugs (15 per cent of medical care costs) and appliances, dental care, and other related expenses.

"We cannot permit the cynicism of minimizing the importance of covering high medical costs for the relatively few who experience them. This is the type of risk which can be catastrophic financially for most families and can create a real financial block to needed medical care."

Legal Responsibilities of Trustees

Physicians who are trustees of hospitals, voluntary organizations, or private corporations have certain specific legal responsibilities which should be fully understood.

At the Annual Conference of Blue Shield Plans in April, 1956, Howard Hassard, legal counsel for Blue Shield Medical Care Plans, presented a paper entitled "The Legal Responsibilities of Trustees." This paper is directed to trustees of Blue Shield plans, but is also an excellent guide for physicians with similar responsibilities in other organizations. Copies may be obtained from the State Medical Society, Box 1109, Madison 1, Wisconsin.

*Reprinted from September, 1956, issue of *Connecticut State Medical Journal.*

For Information or Advice

Write P. O. BOX 1109, MADISON, WIS. Phone ● ALpine 6-3101 MADISON, WIS.

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Dependents' Medical Care Plan

A new and almost unparalleled challenge is before the medical profession in the shape of Public Law 569, the Dependents' Medical Care Act. Some view it simply as a long-deserved fringe benefit for service to one's country. Some see significance in the fact that the act's effective date coincides with an infamous day in American history . . . December 7.

Whatever it may be, DMCP is most certainly a new version of state medicine in private practice. It is *not* prepayment such as Blue Shield. It is *not* public assistance. It is, on the contrary, federal government control of a mechanism under which medical, surgical, and hospital services may be provided by civilian physicians and hospitals to dependents of men in the armed forces at government expense.

Developments during and since enactment of the federal legislation have been rapid and complex. Since December of 1955, the State Medical Society of Wisconsin has been deeply involved in the formulation of the program. Out of its experience in the medical care field, the Society offered knowledge and advice to the American Medical Association and the Department of Defense. It has given substantial time, personnel, and funds in attempts to steer this program into a workable course, at least for Wisconsin. But the effort is only a beginning.

The benefits and method of administration of the program have already been outlined to Wisconsin physicians. Highly significant is the fact that the fees to be paid Wisconsin doctors will, within a reasonable maximum, be those fees which they customarily charge patients for similar services in like circumstances. What is more, by government regulation, no physician can charge more for his services than he would charge were the patient not covered under this particular law.

The implication is clear. The full and complete cooperation of the profession is required if it is to demonstrate an ability to blend a new economic mechanism with medicine's traditional social consciousness and scientific skill.

Similarly, there are many clearly marked danger spots in the government controls associated with this program. Will it follow the pattern of its prototype, the Home Town Care Program for Veterans, in which rules and regulations multiplied to such a point that little care was available through the physician except by prior authorization or under strict and sometimes peculiar control?

Will some governmental agency conclude that what the physician does is not "good medicine" be-

cause it doesn't happen to conform to its concept of medical practice? Will regulations come about specifying qualifications of those performing certain types of operations? Will paper forms be more important to diagnosis than human forms?

Lord Acton, in addressing a class of students, remarked, "It is our function to keep in view and to command the movements of ideas which are not the effect but the cause of public events."

At no time has his comment been more apropos than in relation to DMCP in 1956. Wisconsin physicians, like those throughout the nation, must seize DMCP as an opportunity to urge necessary legislative changes to control bureaucracy, and *not* let bureaucracy control medicine. The real challenge to physicians is "to command the movements of ideas which are . . . the cause of public events."

The Best Physician

Trophilus the Ephesian contended that "He is the best physician who knows what is possible and impossible." Those words might well be engraved in every doctor's office as a constant reminder in the application of scientific skill.

The Blue Book of *The Wisconsin Medical Journal*, due in mid-January, is a modern Trophilus for medical practice. It says: "He is a better physician (and a happier one) who knows what is legal and illegal."

The January issue of the Journal is an unusual collection of articles dealing with the physician's moral and legal responsibilities in medical practice. In addition, it is a guide to a number of important services of the Society and various agencies in Wisconsin. Read it carefully. Refer to it often.

Washington Forecast

Regardless of which party organizes the next Congress or who occupies the White House, health and welfare legislation promises to take up considerable time and attention of lawmakers. The Washington office of the American Medical Association reports there is nothing to indicate that the subject of health has lost its appeal either to the public in general or to men who run for political office in particular.

The national platforms on which the candidates of both parties campaigned are somewhat of a blueprint of things to come in the 85th Congress convening on January 3. The fact that both parties advocate more rather than less federal participation in health and welfare programs is all the more important with the White House and Congress occupied by opposite parties.

Aid to medical schools will be high on the agenda. Voluminous supporting material is being collected by a House staff in anticipation of early hearings. Continued large-scale support for hospital construction and medical research seems inevitable. Both parties are eager to push rehabilitation services for the physically handicapped. Reinsurance is still moving in the background of Republican encouragement of voluntary health insurance, while the Democrats pledged "increased federal aid to public health services . . . especially in rural areas." Almost every politician seems entranced by the magic of the words "social security."

Physicians can make their best contribution to sound legislative development by being informed and passing their knowledge and opinions on to lawmakers.

VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the association, which will be held in the Hotel Statler, New York, May 28, 29, and 30, 1957, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length, and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the association.

. . . . THE PRESIDENT'S PAGE . . . .

The Spirit of Christmas

ONE of my heartening experiences as president of the State Medical Society has been an association with the Student Loan Fund, established to help medical students obtain their professional education. More than $21,000 has been loaned to 31 deserving medical students since the inauguration of this fund in 1951. Eighteen of these students are at the University of Wisconsin Medical School, and 13 others are attending Marquette.

As president I have been reading some of the letters from these men, and they are most appreciative. Perhaps some of you at times needed money while attending medical school. If so, you can appreciate the feelings of the men being helped by the Student Loan Fund, especially when they have a wife and several children and are in debt "up to their neck." The loan sometimes makes the difference between a student's becoming a physician and his being lost to the medical profession.

An interesting feature of the Society's Loan Fund is the fact that no interest is charged until the student completes his internship and is established in practice. Even then the rate of interest is low, but increases steadily as the physician takes more and more time to repay. Repayment of the loan is also waived during military service, although payments may be, and usually are, made during that period.

Some physicians might call this "pampering" our medical students. I don't think so. There is a tremendous need today for these students to be able to get financing during their educational period without any special strings attached. Most of all, I think, this is a good demonstration of the State Medical Society's being willing and able to take care of its own.

Along this line is another activity of the Society which is planned for the future. Early next spring it is cooperating with the two medical schools in Wisconsin in the development of a Senior Medical Student Day at each school. At Marquette the date is to be April 22; the date at Wisconsin is still to be determined. Senior students will be invited to attend, along with their wives, sweethearts, or husbands. These sessions are intended as a helping hand for the prospective physician. There will be a short program related to finding and establishing a practice, important aspects of personal insurance, and some advance information on business problems that the new physician is bound to encounter.

The State Medical Society's Charitable, Educational, and Scientific Foundation has authorized an annual cash award for an outstanding scientific paper prepared by a physician who is completing his residency in a Wisconsin hospital. Details will be announced later, but it seems like a fine idea to encourage research in the budding physician. You know, research doesn't have to be performed in the "ivory towers" of a medical center. There are countless opportunities for the interested physician to perform valuable and productive research in the course of his day-to-day practice. Certainly this program of the Foundation will help instill some of that spirit in the practicing doctor.

It is a real tribute to the State Medical Society that it is doing so much for students of medicine. And, of course, when the student is ready to practice, he can use the Society's placement service for specific planning in locating his practice. At present, this service has listings of more than 100 opportunities in general practice and 23 specialty openings. Some look good enough for me to take!

These are the things that make medicine a proud profession. It is true that the profession's major interest is in the finest kind of public service. Nevertheless, the profession, through its Society, is able to carry out its public interest only to the extent that it can produce devoted, loyal, sincere young men. The physicians of Wisconsin can be mighty proud that their Society is extending the "spirit of Christmas" throughout each and every day of the year with its fine program for medical students.

L. O. Simenstad M.D.

"Wake in our breast the living fires,
The Holy faith that warmed our sires. . . ."
OLIVER WENDELL HOLMES, M. D.

. . . gleanings from the Section on Medical History

The historical highlights of Wisconsin's Rock County are as impressive and as colorful as those of any section of the state. Here are a few samples of the rich heritage:

Janesville's first physician was Dr. James Heath, who came in 1836. He also was an innkeeper, a merchant, and farmer. Dr. S. B. Buckmaster, who wrote a history years ago of the pioneer practitioners of Rock County, narrated this story:

"One dark night Dr. Heath had a sick call on the other side of the Rock River, which was at flood stage. He attempted to swim his horse across, but was swept off the horse's back in midstream and nearly drowned. He was carried almost two miles by the swift current. His wife, attracted by his calls, plunged through the bushes along the shore, encouraging him to continue the struggle. His saddle bags were found several years later, many miles below where he effected a landing."

Doctor Heath left Janesville for the Pacific coast via covered wagon in 1848.

The city of Evansville was named after Dr. John M. Evans, its first doctor. He served in the Wisconsin legislature in 1853 and again in 1873. A son, Dr. J. M. Evans, later practiced in the same community . . . The first water power plant at Indian Ford was developed by Dr. Guy Stoughton . . . Second physician to come to Rock County was Dr. Daniel C. Babcock, who practiced in Johnston and Milton. He was elected to the legislature in 1847 . . . In 1847, when Janesville was a village of 300 residents, Dr. John Mitchell came to practice. He established *The Democratic Standard* in 1851. He was president of the State Medical Society in 1855.

Another physician with newspaper interests was Dr. Robert B. Treat, who helped found *The Janesville Daily* and *The Weekly Free Press* in 1853. He was mayor of the village in 1860 and again in 1863 . . . Dr. Simon Lord, Edgerton, was an assemblyman in 1879 and a state senator in 1882 . . . Porter Township perpetuates the name of Dr. John Porter, who bought some of his land from Daniel Webster.

Dr. Joseph B. Whiting practiced almost 50 years in Janesville. Known as a fine orator and civic-minded citizen, he was a trustee for the State School for the Blind and a member of the city board of education. He was president of the State Medical Society in 1875. In 1889 President Grover Cleveland appointed him to the Chippewa Indian Commission.

Nineteen physicians made Janesville widely known as the "medical center of southern Wisconsin" in 1858 . . . The first hospital in the area was a project fostered by Dr. Henry Palmer, who rented a 20-room mansion for that purpose. It was supported by voluntary contributions . . . Almost all of the Rock County physicians served the Union forces in the Civil War.

* * *

Wisconsin physicians, their wives, and others are invited to contribute items or articles to the Section on Medical History page of *The Wisconsin Medical Journal.* Perhaps you know of someone who did much to further the cause of medicine in this state, or who was a colorful personality, or whose story is one directly connected with medical history. Pictures to go with the contributions are welcomed, too. Another article possibility is the effort of a county medical society or auxiliary working to preserve medical history records or material. Address your contribution to the Section on Medical History, State Medical Society, Box 1109, Madison.

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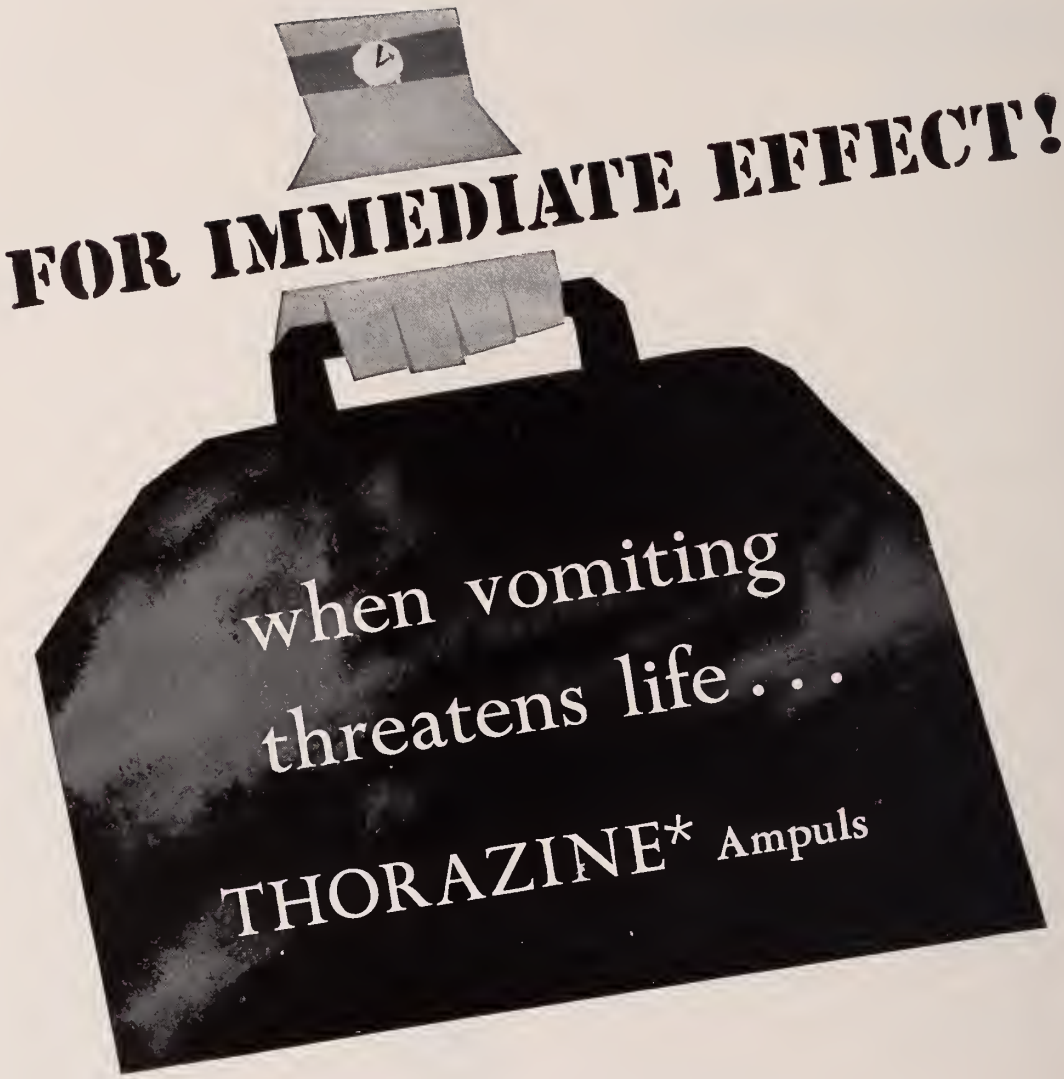

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Society Proceedings

Brown–Kewaunee–Door

Members of the Brown–Kewaunee–Door County Medical Society met October 18 at the Elks Club in Green Bay.

Guest speakers at the meeting were three representatives of insurance companies: Messrs. M. Kiley of Illinois Mutual Casualty, Madison; J. A. Pearce, New York Life, Milwaukee; and F. Field of Equitable Life Assurance Society, Milwaukee. They presented "the case for commercial underwriting of hospital and surgical coverages."

At the November 8 meeting of the society, three physicians spoke on the subject of heart disease. *Dr. Herman Shapiro,* associate professor of medicine at the University of Wisconsin Medical School, and a cardiologist at University Hospitals, Madison, discussed "Diagnosis and Treatment of Rheumatic Heart Disease." "Selection and Preparation of Patients with Acquired Heart Disease for Surgery" was the topic of *Dr. John Huston,* physician in charge of the cardiopulmonary laboratory, Milwaukee County Hospital, and instructor in medicine at Marquette University School of Medicine. The third speaker, *Dr. D. W. Barrow,* professor of surgery at Marquette and assistant surgical director at Milwaukee County Hospital, spoke on "Surgery of Acquired Heart Disease." The Wisconsin Heart Association arranged for the speakers for the meeting.

Dane

The annual meeting of the Dane County Medical Society was held in Madison on October 9.

Guest speaker at the meeting was Mr. T. G. Henry, Jr., representative of the Provident Life and Accident Insurance Company of Chattanooga, Tennessee. Mr. Henry, who is maintaining his headquarters temporarily at the State Medical Society office, was called upon to discuss the group disability program of the State Medical Society.

Reports were given during the business session of the meeting. These included the annual report of the secretary–treasurer, *Dr. Thomas V. Geppert,* Madison; the president, *Dr. R. S. Gearhart,* Madison; the committee on public relations, of which *Drs. C. W. Stoops* and *P. B. Golden,* Madison, are co-chairmen; the audit committee; and the grievance committee.

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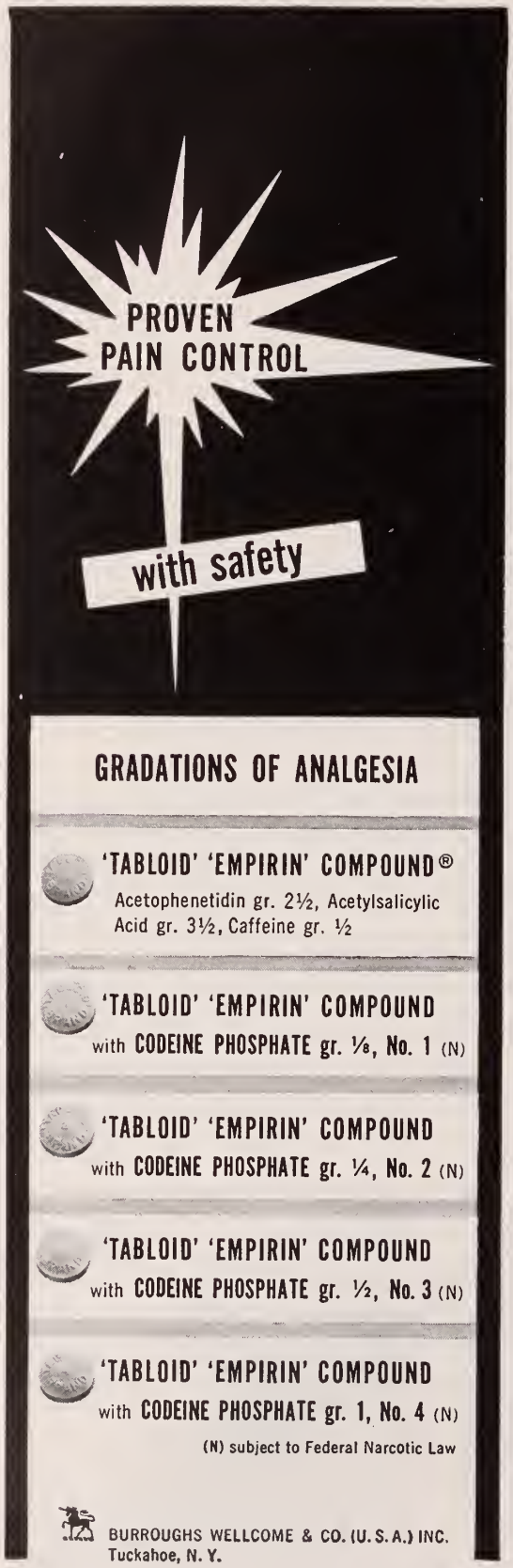


Election of officers was held, and the following were unanimously named:

President-Elect: *T. J. Nereim,* Madison
Vice-President: *R. J. Hennen,* Madison
Secretary–Treasurer: *A. P. Schoenenberger,* Madison
Delegates: *R. S. Gearhart,* Madison; *George Hank,* Madison; *C. W. Stoops,* Madison
Alternate Delegates: *James Land,* Madison; *R. J. Hennen,* Madison; *R. P. Sinaiko,* Madison.

Dr. E. J. Nordby of Madison, who was named president-elect at the annual meeting in 1955, assumed office.

Jefferson

Twenty-four members of the Jefferson County Medical Society met October 18 in Pipersville.

Dr. James M. Sullivan of Milwaukee was the guest speaker, and he addressed the group on "Complications and Treatment of Varicose Veins."

Oconto

The October meeting of the Oconto County Medical Society was held at the Lilac Club in Oconto on October 16.

Election of officers was held, and the following now preside: *Dr. George Mohler,* president; *Dr. Joseph Dougherty,* president-elect; and *Dr. Clyde Siefert,* secretary–treasurer.

Mr. Thomas J. Doran, director of the Wisconsin Veterans Medical Service Agency, was a guest at the meeting.

Outagamie

Members of the Outagamie County Medical Society met October 18 at the Riverview Sanatorium in Kaukauna, as guests of *Dr. John Russo* and his staff.

An expression of approval by unanimous vote of the society was given to the local "Shelter Workshop" program for the handicapped during the business session. Reports of the meeting of the House of Delegates held at the annual State Society meeting were made by *Drs. G. W. Carlson* and *H. T. Gross.* A current report of the activities of the Blood Center was given by Doctor Gross. Colored slides showing the progress of the donor through the Center were shown in addition to a display of equipment and donor records.

Election of officers was held, and the following were named:

President: *J. W. Laird,* Appleton
Vice-President: *G. A. Behnke,* Kaukauna
Secretary: *H. T. Gross,* Appleton
Delegate: *G. W. Carlson,* Appleton
Alternate: *H. T. Gross,* Appleton

Guests at the meeting were Mr. Tom Henry, representative of the Provident Life and Accident In-

surance Company, who spoke on the advantages and benefits of the State Society Group Disability Insurance program, and Mr. Frank Thatcher, Blue Shield district sales coordinator, who talked about the Society's Blue Shield program.

Polk

The Polk County Medical Society met October 18 at the Swedish Cafe in Frederic as dinner guests of *Dr. R. M. Moore.*

Guest speaker at the meeting was Dr. George Tangen of Minneapolis, who addressed the physicians regarding "Hard of Hearing Problems for the General Practitioner." A round-table discussion followed.

Election of officers was held, and the presiding physicians are as follows:

President: *J. C. Belshe*, St. Croix Falls
President-Elect: Stella I. Burdette, Balsam Lake
Secretary: *L. J. Weller*, Osceola
Delegate: *L. O. Simenstad*, Osceola
Alternate: *V. C. Kremser*, Amery
Censor: *K. K. Ford*, Amery.

Sauk

Seventeen members of the Sauk County Medical Society met at the Hotel Warren in Baraboo on October 9.

Mr. William Freis, district social security representative, Madison, was the speaker. His topic was "Old Age and Survivors Insurance Program."

The society, during its business session, agreed to accept the invitation of the Veterans Hospital in Madison to attend the Dearholt Days program on November 13.

Dr. James Trautmann was appointed captain of the civil defense team to succeed *Dr. A. C. Edwards*, who had resigned. *Dr. E. F. Pischke* was named deputy to succeed *Dr. J. A. Booher.*

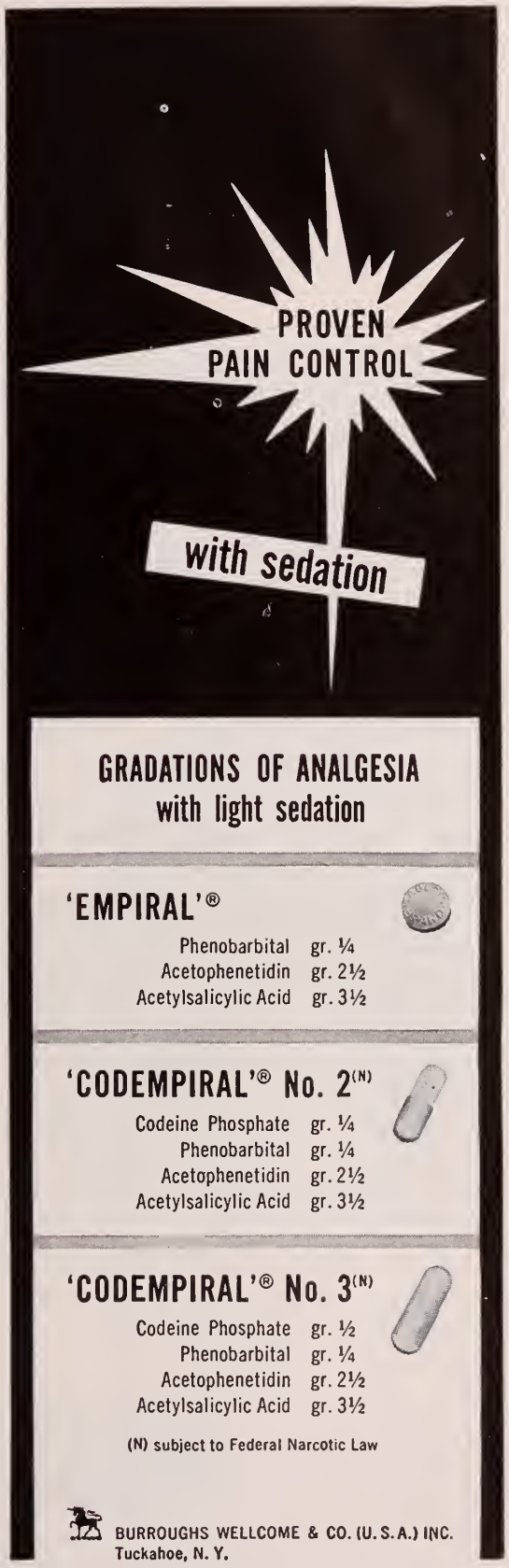
Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society met Tuesday, October 23, at the Eagle Hotel in Fountain City. Dr. Adolf Gundersen spoke on "New Concepts of Arterial Disease."

Waukesha

Dr. John Hitz, a Milwaukee ophthalmologist, discussed the early care of eye injuries and some of the newer developments in the field of ophthalmology at the October 3 meeting of the Waukesha County Medical Society. The meeting was held at Scherers Supper Club in Pewaukee.

All members were invited to participate in the Conference on School Health held on October 18 at the Wisconsin State College, Whitewater.



Winnebago

The Winnebago County Medical Society resumed its fall meetings with a dinner at the Hotel Athearn, Oshkosh, on September 27. Guest speaker Mr. John Hunt, executive secretary of the American Society of Anesthesiology, and graduate of the University of Wisconsin and Northwestern University law schools, discussed "The Economic Status of the Medical Profession."

Ninth Councilor District

Dr. Ben Peckham, professor of obstetrics and gynecology at the University of Wisconsin, was the principal speaker at the quarterly meeting of the Ninth Councilor District held on October 18 at the Hotel Charles, Marshfield. He discussed gynecologic cancer.

The program was preceded by a social hour and dinner.

Tenth Councilor District

New officers elected at the recent annual meeting of the Tenth Councilor District are *Dr. R. R. Richards*, Eau Claire, president, and *Dr. O. G. Moland*, Augusta, secretary–treasurer. *Dr. J. J. Sazama*, Chippewa Falls, is the outgoing president, and Doctor Richards was the former secretary.

Milwaukee Academy of Medicine

The regular meeting of the Milwaukee Academy of Medicine was held Tuesday, October 16, at the University Club in Milwaukee.

Dr. Martin Cherkasky, Director, Montefiore Hospital, New York, was the guest speaker at the scientific session. He spoke on "Home Care of the Chronically Ill."

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News Items and Personals

Dr. F. J. Glassy Locates in Marshfield

Dr. F. J. Glassy recently accepted a post as staff pathologist at St. Joseph Hospital in Marshfield. He replaced *Dr. H. C. Dangle*, who is now at St. Charles Hospital, Aurora, Illinois.

Before locating in Marshfield, Doctor Glassy served as a pathologist at Milwaukee County Hospital. He was an instructor in pathology at Marquette University, and will continue in that position, teaching on a part-time basis. He received his medical degree from Marquette University School of Medicine in 1946 and served his internship and took his residency training at St. Joseph's Hospital, Tacoma, Washington. At one time he studied with Dr. H. Chiari, professor of pathology at the University of Vienna.

Physicians Participate in Panel on Arthritis and Rheumatism

Two Sheboygan physicians and a Milwaukee physician served on a panel at a free public health forum on arthritis and rheumatism which was held November 1 in Sheboygan.

Representing the Sheboygan area were *Drs. L. D. Simonson* and *Robert M. Senty*. *Dr. E. C. Welsh*, Milwaukee, completed the panel.

The free public forum is designed to answer the questions of persons afflicted with arthritis and rheumatism and for friends and relatives of those who suffer from the two cripplers.

THIRD AND TWELFTH DISTRICTS NEWS

Doctor Schultz Opens Madison Office

Dr. A. E. Schultz recently opened an office in the Tenney Building in Madison for the practice of obstetrics and gynecology. He is a graduate of the University of Wisconsin and Northwestern University, also studied at the University of Cincinnati, and took his postgraduate training at Madison General and Wisconsin General hospitals, Madison.

Doctor Bowers Speaks at Watertown

Dr. John Z. Bowers, dean of the University of Wisconsin Medical School, was the guest speaker at the noon luncheon of the Watertown Rotary Club held October 1. "Atomic Energy in Medical Science and Research" was the title of his talk.

New Physician Joins Dr. R. N. Allin

Dr. R. N. Allin recently announced the association with him in his practice of Dr. L. T. Giles. The two physicians will specialize in internal medicine, including allergy, at the Medical Arts Building in Madison.

Dr. Laubenheimer Named Diplomate

It was recently announced that *Dr. Roger Laubenheimer,* Milwaukee, was admitted as a diplomate of the American Board of Dermatology and Syphilology as of October 1, 1956.

Dr. Price Participates in Lecture Series

Dr. Donald O. Price, Madison obstetrician and gynecologist, discussed "Marital Hygiene" in a lecture series of the Association of Childbirth Education on October 18. The lectures are being held at the Madison Vocational School.

SOCIETY RECORDS

New Members

G. P. Gredler,* 1212 Lake Drive, South Milwaukee.

H. R. Peters,* 25 South Madison Avenue, Sturgeon Bay.

B. J. Haza, 401 North Oneida Street, Appleton.

J. S. Veum, 401 North Oneida Street, Appleton.

F. E. Boyd, Route 2, Edgerton.

C. L. Stevenson, Mercy Hospital, Janesville.

R. H. Foss, 305 East Walnut Street, Green Bay.

M. J. Valaske,** Naval Station, Newport, Rhode Island.

J. B. Grace, 306 Cherry Street, Green Bay.

P. D. Christensen, 305 East Walnut Street, Green Bay.

Changes of Address

E. E. Steiger, Plum City, to 23350 Cohasset Street, Conoga Park, California.

Lonnie C. Grant, Jr., Columbia, South Carolina, to % Sudan Interior Mission, Jos, Northern Nigeria, West Africa.

A. E. Kuehn,** New York, to Viroqua.

D. A. Peterson, Waterville, Maine, to 110 East Main Street, Madison.

V. C. Epley,** Fort Sheridan, Illinois, to Prairie du Chien.

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OBITUARIES

Dr. F. J. Schultz, Milwaukee, died October 7 at a Milwaukee hospital after a short illness.

He had practiced medicine in Milwaukee from the time of his graduation from Marquette University School of Medicine in 1907 until January, 1956, when he retired. He was appointed coroner in 1930 to fill an unexpired term, and subsequently was re-elected four times.

He is survived by two sons, Eugene and Sylvester, at home, and two daughters, Mrs. Sylvia Taylor, Milwaukee, and Mrs. Helen Scott of Idaho, Colorado.

Dr. A. J. Williams, a practicing physician in Waukesha for over 40 years and Waukesha's city physician for 14 years, died October 10 at his home. He was 69 years of age.

Doctor Williams was born in Waukesha in 1887. He is an alumnus of the University of Wisconsin and received his medical degree from Rush Medical College, which is now a part of the University of Chicago. He served a one-year internship at St. Mary's Hospital in Milwaukee. During World War I he was a first lieutenant.

Doctor Williams held membership in the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his wife, Vivian; two daughters, Mrs. Marilyn Linley of Long Branch, New Jersey, and Mrs. Juanita Youmans, Waukesha; one son, Arthur J., Waukesha; and nine grandchildren.

Dr. P. T. O'Brien died October 21 at the age of 50 as the result of a plane accident.

Doctor O'Brien was born in 1906 at Milwaukee. He was graduated from Milwaukee Teachers College and from Marquette University School of Medicine, receiving his doctor of medicine degree in 1931. His internship was served at St. Elizabeth Hospital at Appleton, and in 1932 he established his general practice at Menasha. He had been on the staff at St. Elizabeth Hospital for 22 years and also was on the staff of Theda Clark Memorial Hospital, Neenah.

He was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He served as a lieutenant commander in the Navy

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Doctor O'Brien is survived by his widow and two daughters, Paula, Milwaukee, and Colleen at home.

Dr. Aaron Yaffe, 70, a retired Milwaukee physician, died at a Milwaukee hospital on October 13 after a long illness.

Doctor Yaffe was born in Germany and was brought to the United States as a small boy. He was reared in Ashland, Wisconsin. In 1908 he graduated from the school of medicine at the University of Michigan. He interned at Milwaukee hospital and was a resident physician in the old Johnston Emergency Hospital before establishing a private practice.

After serving in the army medical corps in World War I, he returned to Milwaukee and began private practice. He continued his Milwaukee practice until his retirement in July, 1956.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the Milwaukee Academy of Medicine.

Survivors include his wife, Aimee; a son, Frank H., Milwaukee; and a sister, Mrs. Sally Becker, Los Angeles, California.

Dr. George W. Reis, who had practiced at Junction City for 40 years, died October 23 at Marshfield. Doctor Reis was the only physician in western Portage County.

He was born in Random Lake in 1886. In 1912 he graduated from the Marquette University School of Medicine, after which he practiced for three years at Star Prairie, before moving to Junction City.

He was a member of the Portage County Medical Society, past president of the Ninth Councilor District, and a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his wife, Florence; a son, George, Jr., at home; a daughter, Mrs. Charles Amann, Birmingham, Michigan; and two grandchildren.

Dr. W. C. Hanson, a physician for 60 years, died October 23 at his home. He was 84 years of age.

Doctor Hanson, who was born in the Town of Norway, was one of the oldest practicing physicians in the state. In 1897 he was graduated from the Milwaukee School of Medicine, which is now Marquette University School of Medicine. After graduation, Doctor Hanson began his practice in Beaver Dam. In 1898, after one year there, he moved to North Cape, where he practiced for 16½ years before moving his office into Racine. On March 31, 1947, he celebrated his fiftieth anniversary in the practice of medicine.

Doctor Hanson served for two years in the army during World War I in overseas medical camps, being discharged as a major.

His professional affiliations included the Racine County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and

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the American College of Surgeons. He was also a Fellow in the Association of Industrial Physicians and Surgeons.

Surviving are his wife, Esther, and one daughter, Mrs. Dorothy Anderson.

Dr. W. R. Notbohm, who had served as a physician in Dousman for the past 58 years, died October 23 at his home at the age of 90.

He was born in 1865 in the town of Sullivan. In 1898 he graduated from the Milwaukee Medical College, and immediately after graduation began private practice. He was the first physician to locate in Big Bend; six months later he moved to Dousman.

Doctor Notbohm estimated that he had delivered more than 2,500 babies. Residents of the community showed their affection for him at a celebration in 1952, at which he was feted by the Dousman Community Club. Again, on the occasion of his 90th birthday, November 10, 1955, throngs of friends attended his open house anniversary celebration to wish him well.

He was a member of the Waukesha County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Two sons, Dr. DeLon, Fort Atkinson, and A. W., of Delafield, survive.

Correction

In our September issue, page 1018, the first name of Doctor Bilstad of Cambridge, who died on June 26, was incorrectly listed as Charles. His first name was Gunerius.

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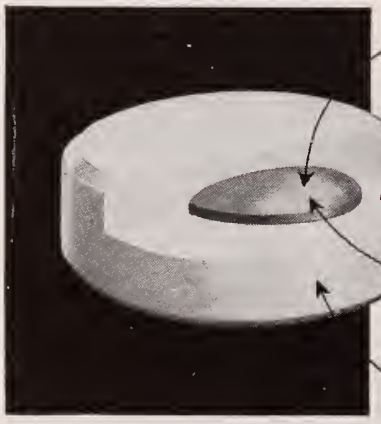

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RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Milwaukee, July 11, 1956.

Name	*School of Graduation*	*Year*	*Address*
Bacchus, Azeez	Howard University	1954	Milwaukee County Hospital, Milwaukee.
Blahnik, C. L.	Marquette University	1954	Lena.
Blum, F. G., Jr.	George Washington University	1954	2210 Keyes Ave., Madison.
Chambers, E. L., Jr.	Stanford University	1952	University Hospitals, Madison.
Christoff, Christo	University of Vienna	1929	Milwaukee Hospital, Milwaukee.
Dale, H. L.	Meharry Medical College	1943	400 N. 17th St., Birmingham, Alabama.
Davis, Jean P.	Yale University	1943	324 E. Wisconsin Ave., Milwaukee.
Elconin, A. N.	Western Reserve University	1951	Mount Sinai Hospital, Milwaukee.
Foderick, P. P.	University of Western Ontario	1953	Plum City.
Fox, C. R.	University of Wisconsin	1951	3321 N. Maryland, Milwaukee.
Giffin, Eleanor E.	New York Medical School	1952	39 S. Main St., Fond du Lac.
Grace, J. B.	Northwestern University	1950	306 Cherry St., Green Bay.
Henkle, R. F.	University of Iowa	1953	549 W. Grand Ave., Port Washington.
Hooper, C. H.	Vanderbilt University	1952	Sheboygan Clinic, Sheboygan.
Kennedy, E. D.	Indiana University	1952	501½ Third St., Wausau.
Koch, J. S.	University of Iowa	1954	University Hospitals, Madison.
Koll, Jane H.	University of Colorado	1951	Medical Arts Bldg., Oak Ridge, Tennessee.
Lange, S. J.	Northwestern University	1926	636 Church St., Evanston, Illinois.
Lerner, A. G.	University of Wisconsin	1954	University Hospitals, Madison.
Marks, L. M.	Rush Medical School	1940	2405 E. 100th, Chicago, Illinois.
Nilssen, W., Jr.	University of Wisconsin	1951	Weaverville, California.
Ozonoff, M. B.	Northwestern University	1954	3446 N. Frederick, Milwaukee.
Poindexter, G. W.	Meharry Medical College	1952	6209 W. Custer, Milwaukee.
Potter, P. H.	Northwestern University	1951	1724 Greysolon Rd., Duluth, Minnesota.

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John E. Leach, M. D. — John R. Whitty, M. D.

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Name	*School of Graduation*	*Year*	*Address*
Saltzstein, S. L.	Johns Hopkins University	1954	Washington University School of Medicine, St. Louis, Missouri.
Slungaard, Rolv	University of Oslo, Norway	1950	1836 S. Ave., La Crosse.
Smith, C. C.	Northwestern University	1954	1142 S. Jackson, Green Bay.
Snyder, J. F., III	Yale University	1953	926 Golf Lane, Wheaton, Illinois.
Steidinger, C. L.	University of Illinois	1953	329 E. Main, Platteville.
Stevenson, C. L.	University of Wisconsin	1952	Mercy Hospital, Janesville.
Vana, A. J.	Stritch School of Medicine	1949	Midelfart Clinic, Eau Claire.
Warner, W. A.	University of Wisconsin	1953	2120 Banks, Superior.
Wickliffe, C. D.	University of Louisville	1953	219 6th St., Calumet, Michigan.

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 10–12, 1956.

Name	*School of Graduation*	*Year*	*Address*
Anderson, H. C.	University of Wisconsin	1955	400 N. Harrison, Stoughton.
Appel, L. L.	Ohio Medical School	1955	University Hospitals, Madison.
Atwood, W. H., Jr.	University of Wisconsin	1955	2223 University Ave., Madison.
Bailey, D. W.	University of Wisconsin	1955	2655 N. 38th, Milwaukee.
Baumblatt, G. J.	University of Wisconsin	1955	2979½ Northview Blvd., Youngstown, Ohio.
Belanger, W. R.	Marquette University	1955	1719 Reeve St., Appleton.
Beltran, D. J.	University of Wisconsin	1953	VA Hospital, Wood.
Bergwall, J. G.	Marquette University	1955	49 Metlin Ave., Akron, Ohio.
Bertoglio, A. L.	Marquette University	1955	Akron General Hospital, Akron, Ohio.
Blum, J. V.	Columbia University	1955	425 Lorch St., Madison.
Braswell, H. M., Jr.	University of Arkansas	1955	Owen Clinic, Owen.
Brisbin, Robert L.	University of Wisconsin	1955	Marine Corps, Miami, Florida.
Brown, R. O.	University of Wisconsin	1955	8700 W. Wisconsin Ave., Milwaukee.
Burnett, G. H.	University of Chicago	1954	University Hospitals, Madison.
Craig, J. L.	University of Wisconsin	1952	Youngstown Hospital, Youngstown, Ohio.
Crandall, G. H.	University of Wisconsin	1955	323 E. Central Ave., Richland Center.
Damiano, N. F.	Marquette University	1955	4228 W. Oklahoma Ave., Milwaukee.
Devine, J. C., Jr.	Marquette University	1955	70 Woodland Ave., Fond du Lac.
Douglas, R. F.	University of Wisconsin	1955	University Hospitals, Madison.

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Dracopoulos, T. T.	University of Wisconsin	1955	2200 W. Kilbourn, Milwaukee.
Driscoll, L. J.	University of Wisconsin	1955	P. O. 31, Oconomowoc.
Dushack, W. H.	University of Wisconsin	1955	Milwaukee Hospital, Milwaukee.
Ebling, P. R.	University of Wisconsin	1955	University Hospitals, Madison.
Epstein, Ernst	Marquette University	1955	807 W. 5th, Marshfield.
Farrar, M. C.	University of Wisconsin	1953	552 Peachtree, Atlanta, Georgia.
Fieber, W. W.	University of Wisconsin	1955	Lancaster.
Foley, W. J.	Marquette University	1955	6713 W. Wisconsin Ave., Milwaukee.
Gieschen, V. W.	University of Wisconsin	1955	4813 W. Santa Barbara, Los Angeles, California.
Goral, T. J.	Marquette University	1955	2201 N. 41st, Milwaukee.
Grassl, F. O.	University of Wisconsin	1955	River Falls.
Gustafson, R. T.	University of Wisconsin	1955	1510 Main St., Marinette.
Hammes, J. R.	Marquette University	1955	2511 Jerome Blvd., Racine.
Hessburg, P. C.	Marquette University	1955	817 Robertson, Wauwatosa.
Hinke, M. L.	University of Wisconsin	1955	Stanley.
Hobson, W. S.	University of Wisconsin	1955	341 S. Madison, Chilton.
Holaday, W. J.	New York Medical School	1955	Midelfart Clinic, Eau Claire.
Hughes, J. B.	University of Wisconsin	1955	454 W. N.Y. Avenue, Oshkosh.
Jaeckels, M. T.	Marquette University	1955	4012 N. Prospect, Milwaukee.
Joseph, L. G.	University of Wisconsin	1954	VA Hospital, Iowa City, Iowa.
Joyce, J. W.	Stritch School of Medicine	1955	548 Bostwick, Janesville.
Kashgarian, Mark	University of Basel, Switzerland	1954	955 N. 13th, Milwaukee.
Kippenhan, J. E.	University of Wisconsin	1954	1107 Jacqueline, Kileen, Texas.
Kirchner, M. M.	Northwestern University	1955	2803 E. Belleview, Milwaukee.
Komar, R. R.	Marquette University	1955	Brookfield.
Kraus, R. F.	Marquette University	1955	2508 E. Belleview, Milwaukee.
Kritter, A. E.	Marquette University	1955	Columbia Hospital, Milwaukee.
Krohn, J. I.	Northwestern University	1955	Krohn Clinic, Black River Falls.
LaFond, D. J.	Marquette University	1955	1254 N. 24th, Milwaukee.
LaKritz, L. W.	Marquette University	1955	5318 N. 29th, Milwaukee.
Lescher, C. F.	Marquette University	1955	534 N. Monroe, River Forest, Illinois.
Mataczynski, R. R.	University of Wisconsin	1955	1521 Hammond, Superior.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Name	*School of Graduation*	*Year*	*Address*
Maxwell, G. M.	University of Edinburgh, Scotland	1954	University Hospitals, Madison.
Miller, T. O.	University of Wisconsin	1955	Mendota State Hospital, Madison.
Monson, Sonja D.	University of Wisconsin	1955	Mendota State Hospital, Madison.
Mooney, F. L.	Marquette University	1955	3026 W. National Ave., Milwaukee.
Murray, Marvin	Wayne University	1955	University Hospitals, Madison.
Nelder, K. H.	University of Minnesota	1955	Red Cedar Clinic, Menomonie.
Nellen, J. R.	Marquette University	1955	351 E. Schiller, Milwaukee.
Nickels, R. J.	Indiana University	1955	Southern Colony, Union Grove.
Novotny, C. A.	Marquette University	1955	721 W. Vliet, Milwaukee.
O'Connor, T. M.	Marquette University	1955	4073 N. 18th, Milwaukee.
Olsen, E. H., Jr.	Marquette University	1955	Hospital for Mental Diseases, Milwaukee.
Pawlowski, E. J.	Marquette University	1954	1758 N. Rhodes, Arlington, Virginia.
Pawlowski, J. M.	Marquette University	1953	U. S. Naval Hospital, Portsmouth, Virginia.
Pawlowski, M. M. F.	Marquette University	1954	1758 N. Rhodes, Arlington, Virginia.
Pletcher, W. D.	Northwestern University	1955	1201 S. 8th, Goshen, Indiana.
Pollay, Michael	University of Wisconsin	1955	University Hospitals, Madison.
Puskar, A. T., Jr.	Loyola Medical College	1955	Milwaukee County Hospital, Milwaukee.
Radlet, P. J.	University of Wisconsin	1955	University Hospitals, Madison.
Richter, A. M.	Marquette University	1955	3133 S. Illinois Ave., Milwaukee.
Rockey, J. H.	University of Wisconsin	1955	3224 Tally Ho Lane, Madison.
Sabin, R. P.	University of Wisconsin	1955	University Hospitals, Madison.
Sachtjen, K. M.	University of Wisconsin	1955	5 Sherman Terrace, Madison.
Sandmire, H. F.	University of Wisconsin	1953	University Hospital, Iowa City, Iowa.
Sargeant, C. D.	Northwestern University	1955	1825 New York, Manitowoc.
Schlichting, J. E.	University of Wisconsin	1955	612 Huron Ave., Sheboygan.
Schorer, C. E.	University of Wisconsin	1955	3758 Baldwin, Detroit, Michigan.
Schumacher, D. R.	University of Iowa	1955	215 W. Lawrence, Appleton.
Schwartz, W. R.	University of Wisconsin	1955	Box 386, Lancaster.
Sevenich, J. R.	Marquette University	1955	1835 Jefferson Ave., St. Paul, Minnesota.
Siebert, J. T.	University of Wisconsin	1955	509 Camp St., Baraboo.
Skemp, S. J.	Marquette University	1955	1615 Main St., La Crosse.
Skupniewicz, R. E.	University of Wisconsin	1955	710 Main St., Racine.
Smith, E. J.	University of Wisconsin	1955	Franksville.
Stebbins. G. G., Jr.	University of Wisconsin	1955	1016 Sherman Ave., Madison.

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Name	*School of Graduation*	*Year*	*Address*
Toll, R. J.	University of Wisconsin	1954	2221 N. View, Manhattan, Kansas.
Travis, Ann M.	University of Wisconsin	1955	London WC–1, England.
Travis, J. W.	Northwestern University	1955	333 E. Huron, Chicago, Illinois.
Tribbey, J. A.	Marquette University	1955	5433 N. 61st St., Milwaukee.
Trumble, E. A.	University of Cincinnati	1954	University Hospitals, Madison.
Van Lieshout, F. X.	Marquette University	1955	126 E. Main, Little Chute.
Voge, L. C.	Marquette University	1955	6513 W. Custer, Milwaukee.
Weber, J. C.	University of Wisconsin	1955	516A N. 8th, Sheboygan.
Webster, T. C.	University of Wisconsin	1955	4005 Citradora Dr., Spring Valley, California.
Wein, Benjamin	University of Wisconsin	1955	3038 N. 39th, Milwaukee.
Weisenthal, C. L.	Chicago Medical School	1955	VA Hospital, Wood.
Werner, D. L.	University of Wisconsin	1955	107 High St., Randolph.
Weston, E. L.	University of Wisconsin	1955	University Hospitals, Madison.
Wett, R. J.	Marquette University	1955	Box 314, Walworth.
Wheaton, R. C.	University of Wisconsin	1955	310 S. Page St., Stoughton.
Whetstone, O. H.	Stritch School of Medicine	1954	8700 W. Wisconsin Ave., Wauwatosa.
Whiffen, J. D.	University of Wisconsin	1955	University Hospitals, Madison.
Wilhoite, R. W.	Marquette University	1955	2320 N. Lake Dr., Milwaukee.
Wilson, A. H.	University of Washington	1954	Milwaukee Hospital, Milwaukee.
Wolfgram, R. C.	University of Wisconsin	1955	358 W. Algoma St., Oshkosh.
Yurich, E. L.	University of Wisconsin	1955	9331 Rutherford, Detroit, Michigan.
Zastrow, R. C.	Marquette University	1955	VA Hospital, Wood.
Zatlin, Gerald	University of Wisconsin	1955	1202 Crooks St., Green Bay.
Zlatnik, Mary A.	University of Wisconsin	1955	306 Grafton Ave., Newark, New Jersey.
Zuege, R. C.	Marquette University	1955	Columbia Hospital, Milwaukee.

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Surgery of Colon & Rectum, One Week, March 4
General Surgery, One Week, February 11
General Surgery, Two Weeks, April 23
Surgical Anatomy & Clinical Surgery, Two Weeks, March 4
Surgical Pathology, 2 or 4 Weeks, by appointment
Basic Principles in General Surgery, Two Weeks, January 14
Fractures & Traumatic Surgery, Two Weeks, March 11
Anesthesia, 2 or 4 Weeks, by appointment

GYNECOLOGY & OBSTETRICS—Office & Operative Gynecology, Two Weeks, February 11
Vaginal Approach to Pelvic Surgery, One Week, February 4
General & Surgical Obstetrics, Two Weeks, February 25

MEDICINE—Electrocardiography & Heart Disease, Two-Week Basic Course, March 11
Gastroenterology, Two Weeks, May 13
Dermatology, Two Weeks, May 6
Gastroscopy, Two Weeks, March 18

RADIOLOGY—Diagnostic X-Ray, Two Weeks, February 4
Clinical Uses of Radioisotopes, Two Weeks, May 6

UROLOGY—Two-Week Course, April 1
Cystoscopy, Ten Days, by appointment

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THE MEDICAL FORUM

What Brought Dr. Braswell to Wisconsin?

Recently The Milwaukee Journal and the J.A.M.A. carried long feature articles telling about the arrival of **Dr. H. M. Braswell jr.**, in Owen, a Clark County community which had been without a physician for two years.

Asked what made him select a small town in upstate Wisconsin, Dr. Braswell, a native of Dallas, Tex., said:

"Two factors decided me on Wisconsin.

"First, I liked the state. People are friendly, and there's good fishing and hunting.

"Second, the State Medical Society seemed more interested in helping a doctor locate than the societies of several other states."

ON THE S.M.S. CALENDAR . . .

DECEMBER

19—Claims Committee, S.M.S.
25—MERRY CHRISTMAS!
31—HAPPY NEW YEAR!

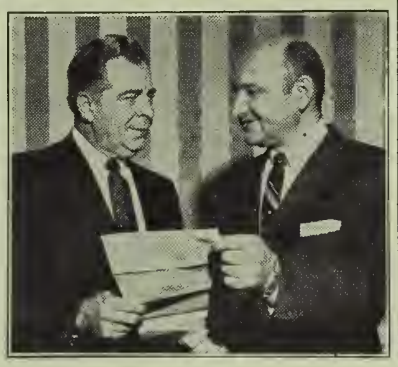
JANUARY

12—Council on Medical Service, Milwaukee
15—Post-Graduate Clinic, Madison
16—Post-Graduate Clinic, Oshkosh
17—Post-Graduate Clinic, Sheboygan
17–18—Mid-Winter Conference and Exposition, Wisconsin Council of Safety, Milwaukee
19—Division on Public Assistance, S.M.S.
26–27—National Blue Shield Commission, Chicago

FEBRUARY

10–12—Congress on Medical Education and Licensure, Chicago
11–13—National Blue Shield Professional Relations Conference, Chicago

MAY 7–9—ANNUAL MEETING, MILWAUKEE!



GREAT DAY—when the State Medical Society acquired the old Ft. Crawford Military Hospital at Prairie du Chien, thus enabling it to go ahead with plans for a Wisconsin Medical Museum. In this picture, Dr. E. L. Bernhardt (left), Milwaukee, President of the Society's Charitable, Educational and Scientific Foundation and Dr. E. M. Dessloch, Prairie du Chien, Vice-Chairman of its Section on Medical History look over the quit claim deed acquired from the Dr. William Beaumont Memorial Foundation. — (Philip C. Dittes Photo)

SET UP NEW JOB PLACEMENT PLAN FOR MED ASSISTANTS

MADISON—It should be easier now for physicians to find medical assistants, and for prospective assistants to find jobs.

A joint effort of the Wisconsin State Medical Assistants Society, the State Medical Society and the Wisconsin State Employment Service has resulted in a new program for placing medical assistants in vacancies around the state.

Physicians are urged to write, phone or visit any of the 26 district offices of W.S.E.S. if they need an assistant. Persons interested in finding employment in this field are urged to register at one of the offices as soon as possible.

The program covers assistants serving in the following capacities:

Receptionist, secretary, physician's assistant, practical nurse, office nurse, doctor's laboratory office assistant; chief x-ray technician, x-ray technician, automatic x-ray developing machine operator, electrocardiograph technician, physical therapist,

(Continued on page 1382)

FORT HOSPITAL SET FOR SHRINE

MADISON—The State Medical Society is a great stride closer to its dream of a Wisconsin Medical Museum.

Acquisition of the old Ft. Crawford military hospital at Prairie du Chien was announced last month by the Society's Charitable, Educational and Scientific Foundation. The property was acquired by quit claim deed from the Dr. William Beaumont Memorial Foundation, which has owned the land and building since 1943.

Previously, the property had been purchased and partly restored by the Prairie du Chien chapter of the Daughters of the American Revolution.

The proposed museum will particularly honor Dr. Beaumont, 19th century army surgeon, and Dr. Walter B. Cannon, both of Prairie du Chien. The former conducted experiments in gastric juices and digestion 120 years ago. Dr. Cannon is credited with discovering that the stomach moves while it is digesting food.

Other physicians will be honored in the museum.

The S.M.S. Foundation was scheduled to meet this month to outline plans for the restoration project. It hopes to raise $250,000 or more to establish and maintain the museum. Already stocks of books, pictures, medical instruments and other historical items have been collected for the medical shrine.

17 MED SCHOOLS IN CONSTRUCTION

CHICAGO — Seventeen medical schools—16 in the United States and one in Canada—recently reported completion of construction projects costing $65,000,000.

Seventeen other schools in this country and two in Canada have undertaken new projects to cost $45,000,000.

WIAA: FACE MASKS CUT DOWN FOOTBALL INJURIES

Concussions, Broken Noses, Other Injuries Reduced

MARINETTE — When high school football players wear facial masks, injuries are reduced more than 60 per cent, according to a report filed recently by the Wisconsin Interscholastic Athletic Association.

Use of the masks virtually eliminates concussions, a major injury hazard, the W.I.A.A. said. Broken noses were greatly reduced, as were several other types of face and mouth injuries, when masks were worn.

DIVISION INSPIRED

Use of the masks followed recommendations of the State Medical Society's Division on School Health to make the game a safer one for participants.

More than 8,990 boys in 303 member schools agreed to wear the masks on an experimental basis in 1955. The players wearing masks suffered 183 injuries that season; 6,721 other athletes not using the masks suffered 351 injuries to the face and head.

Clifford B. Fagan, executive secretary of the W.I.A.A., said the percentage of injuries to boys wearing masks was two per cent, compared with 5.1 per cent for those not wearing them.

HIGHLY EFFECTIVE

Face masks proved to be 93 per cent effective in eliminating concussions, reducing incidence of this type of injury from 30 to two; 82 per cent in eliminating broken noses, from 70 to 12; and 96 per cent in preventing unclassified injuries.

There were 121 tooth injuries among those equipped with masks, and 167 to those who were not. Because this was not as effective as anticipated, the use of rubber mouthpieces, such as worn by boxers, will be recommended.

Fagan said the W.I.A.A. Board of Control was most enthusiastic over the results attained, and intends to foster use of the masks whenever and wherever possible during future seasons. Board members were agreed that the expenditure of $14,125 to subsidize the program was warranted in averting a number of serious injuries. The project also resulted in a substantial saving to the Association's Athletic Benefit Insurance Plan.

Fagan said the study pointed up the fact that proper attention is not always given to proper fitting of the mask to the wearer. There was evidence, he said, that equipment which fits improperly represents a hazard to the wearer, rather than a protection.

Five types of masks were used, with variations in transparency and attachment to the helmet. Each participating school had its choice.

NOT MEN FROM MARS — but high school football players equipped with protective facial masks, as described in the accompanying article. The athletes are members of Madison prep teams. One of the face bars (right) is a flat, transparent device; the other is a moulded opaque shield.— (Madison Capital Times Photo)

DETERT NAMED HEAD OF NATIONAL CLINIC ASSOCIATION

NEW ORLEANS, LA. — Floyd R. Detert, manager of the Marshfield, Wis., Clinic, was named president-elect of the National Association of Clinic Managers at its meeting here in November.

He will assume the office of president next October. In 1948–50, he served as secretary of the national group.

The Marshfield Clinic was one of 15 founders of the N.A.C.M. in 1926.

HOXSEY MENACE CONTINUES, U. S. OFFICIAL WARNS

WASHINGTON, D. C.—A recent court ruling against the Hoxsey cancer treatment does not end the menace of this fake treatment, George P. Larrick, Federal Commissioner of Food and Drugs, said in a recent statement.

The Pittsburgh Federal Court, following a six-week trial, returned a jury verdict that the Hoxsey medicines for internal cancer are worthless, and that these medicines, in pill form, were illegally offered as an effective treatment for cancer.

It was the second such ruling by a Federal Court.

Larrick said 500,000 of the Hoxsey pills, seized shortly after the opening of the second Hoxsey Clinic at Portage, Pa., would be destroyed, and that an injunction is being sought to stop further interstate shipment of the pills.

"We intend using every legal means within our power to protect consumers from being victimized by this worthless treatment," the Commissioner said.

LEARN THE FACTS!

"In the meantime, it is of the utmost importance that cancer patients and their families, who may be planning to try the Hoxsey treatment either at Portage or Dallas, Tex., should acquaint themselves with the facts.

"Hoxsey has continued to promote his worthless cure for more than 30 years, notwithstanding numerous local and state court actions. Proceedings under the Federal laws did not appear possible until a 1948 decision by the U. S. Supreme Court clarified the statutes. An injunction suit was filed in 1950 and a decree finally issued in Dallas in 1953."

Larrick said the Pittsburgh trial brought out testimony concerning persons who may have died of cancer as a result of reliance on the Hoxsey treatment instead of seeking competent medical treatment in the early stages of their condition.

ODDS 'N ENDS . . .

Think your tissue committee is tough? Some 4,000 years ago, the Code of Hammurabi stipulated that if a doctor opened an abscess and preserved the sight of a patient, he would receive 10 silver shekels. However, if the patient lost his sight or his life, the physician was punished by having his hands cuts off . . . *Missing from the ranks these days is the City of London Truss Society for the Relief of the Ruptured Poor. The unique group was founded in 1807 and was still active 75 years later* . . . Proud of your new office building, or clinic, Doctor? Then send *The Medical Forum* a picture of it, and send along details re facilities, staff etc. . . . We'll tell others about it. . . . **Like to bowl, and have fun socially with others in your profession? Then join other Wisconsin physicians at Wisconsin Rapids Feb. 2 when the First Annual S.M.S. Bowling Tournament will be staged. Fine accomodations in that city, and the Wood County Medical Society plans a grand party for the entries and their ladies that evening . . .** Remember Alice Marble, who ruled the tennis world (fair sex division) a decade ago? She's a medical assistant in California now. . . More than 25 per cent of the S.M.S. membership has sent in $10 (or more) for a contribution to the Charitable, Educational and Scientific Foundation. **Have you?** . . . Any time you find old papers, medical instruments, pictures and the like which have a background in Wisconsin's medical history, give thought to sending them to the Society's Section on Medical History. You'll be helping perpetrate our rich heritage and perhaps be making a contribution to the Wisconsin Medical Museum, no longer over the distant horizon but in sight . . . Suggestions for stories or news articles in *The Medical Forum* are always welcome . . . **Why not start mapping plans now to make sure you'll be in attendance at the Society's 116th Annual Meeting in Milwaukee May 7–9?** The program and side events promise to be better than ever, and that's no mere publicity plug. . .

MAP PLANS FOR UPSTATE PRE-MATURITY INSTITUTES IN MAY

MADISON — Development of Pre-Maturity Institutes for benefit of hospitals in northern Wisconsin was recommended by the Society's Division on Maternal and Child Welfare at its November meeting.

Also urged was a speakers' service to interpret findings of the Maternal Mortality Study Committee from its inception in 1952 to date.

The Division suggested institutes in Eau Claire, Superior and Wausau in late May or early June. Previous sessions were held in Green Bay, Madison and Milwaukee.

Drs. Thomas V. Geppert, Madison; Stewart L. Griggs, Green Bay and Kennth J. Winters, Wauwatosa, who assisted with earlier meetings, will be asked to serve again, aided by help from local ophthalmologists and pathologists.

Hospitals will be asked to make use of speakers provided through the Study Committee to detail significant findings in relation to special dangers and proper management in reference to deliveries.

Dr. Amy Louise Hunter, of the State Board of Health, presented a report on anesthesia practices in Wisconsin hospitals. Her report was based upon a 75.6 per cent return of a questionnaire sent several months ago. A complete report will be made later.

Dr. Hunter also informed the Division of the possible availability of federal funds for a long-range program designed to provide physicians with more help in advising parents how to handle problems of their mentally retarded children.

The program calls for special teaching programs at the University of Wisconsin and Marquette University medical schools, and possibly in other locations, to alert physicians as to existing resources. Community and home programs are to be arranged to help meet the problems of the 14,000 children in the state who cannot meet usual demands of school and vocational life.

Med Assistants Elect Miss Budny

MILWAUKEE — Alice Budny, who served as the first president of the Wisconsin State Medical Assistants Society, was elected recording secretary of the American Association of Medical Assistants Oct. 28.

The national group held its constitutional convention here, also electing officers and picking San Francisco as the site of its 1957 session.

Maxine Williams, Kansas City, Kans., was elected the first president of the Association.

Drs. Devitt, Milwaukee; Dorchester, Sturgeon Bay and Fencil, Monroe, represented the State Medical Society's Council on Medical Service at the convention.

Continuity of Income is *a vital issue,* and in most cases it remains so after 65

TIME HEALTH INSURANCE policies are not terminated nor are benefits reduced because of age.

T·I·C

TIME INSURANCE COMPANY

MILWAUKEE WISCONSIN

A Forum Feature . . .

PHYSICIAN VITAL FORCE IN REHABILITATING DISABLED

Preparing Handicapped Persons for Employment An Essential Effort

MADISON — The role of the physician in employment of the physically handicapped is not generally understood.

It *is* generally recognized that employment is important medicine in the total rehabilitation of the handicapped. This concept is not new. Before the time of Christ, a physician in Asia Minor, Galen, wrote:

"Employment is nature's best physician."

M. D. IS THE HUB

The physician is the backbone of the team in rehabilitating the physically handicapped and returning him to the normal activities of life and to gainful employment.

To illustrate this point, visualize a large wheel revolving around an axle. Consider the axle as the patient, the hub as the M.D., the spokes as the various medical services of the rehabilitation center, such as physical therapy, occupational therapy, speech therapy, vocational counselling, psychological and medical social services and pre-vocational services.

The rim of the wheel represents active living and gainful employment. Thus, one can see the vital role the physician plays in the entire wheel of activity about the patient. The end goal is total rehabilitation.

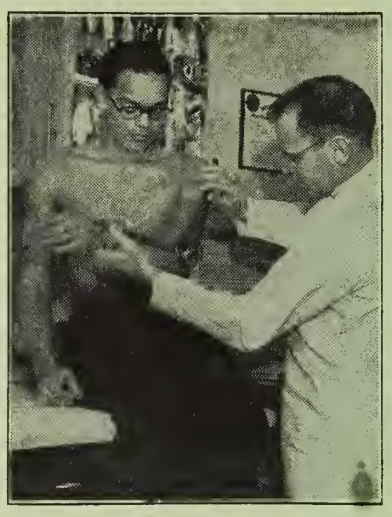
The physician must serve as team captain and consider each phase of rehabilitation of equal importance. All members of the team must be free to express their views, as well as make recommendations to assure a successful result.

This is more important in the chronically ill than in the acutely ill patient.

KNOW PATIENT

The patient's hopes, desires and feelings must be understood if the disease is to be combatted successfully. Consideration also must be given the patient's family, his friends and his role in the community.

So, in considering medicine in the total rehabilitation picture of the physically handicapped, em-



ployment is not stressed as an economic factor but purely as a therapeutic measure in the full program. Partial employment of the individual under medical supervision helps to advance him to the final stage of rehabilitation, which is full employment within the limits of his own physical capacity.

HANDICAP SECONDARY

The stigma of qualifying these handicapped persons as "crippled" has been as huge a handicap to them as their physical limitations. The tendency to set apart the person who is different because of a conspicuous defect is being corrected by the realization that the handicapped is *first* a person, and his handicap only secondary.

What's being done nationally and in Wisconsin to bring about this realization?

"GOOD BUSINESS"

In 1947 the President's Committee for Employment of the Physically Handicapped was organized. A voluntary group, it is made up of doctors, lawyers, public spirited citizens, union representatives and others. The work is educational, finding ways and means to convince employers that "It's Good Business to Hire the Handicapped."

The next stage was to interest governors of all the states to form committees operating on local levels. The state groups call statewide attention to existing problems.

The Wisconsin State Employment Service provides employment counselling and placement service for handicapped persons, and promotes and develops opportunities. The Service works together with the Rehabilitation Division of the State Board of Vocational and Adult Education, and these services are provided:

Individual counselling and guidance; medical examination; medical, surgical, psychiatric and/or hospital treatment; prostheses, such as braces, limbs, hearing aids; occupational and physical therapy; apprenticeship, and others.

The Division placed 1,365 persons in jobs in 1955, 103 of them formerly on relief rolls.

WSES reported it had placed 4,370 handicapped persons in jobs during the first nine months of 1956. This represented five per cent of all Wisconsin placements.

A DIVISION PROJECT

Since 1953, education for physicians and laymen has been the major effort of the State Medical Society's Division on Rehabilitation. An extensive program of lectures, talks, demonstrations and publications was arranged, encouraged and sponsored by the Division. Its chairman is Dr. Robert W. Boyle, Milwaukee.

The Division also studies new and proposed legislation in the field of rehabilitation. It maintains close liaison between itself and various agencies working in the same field.

The Division seeks to impress physicians with the great need of:

1. Knowing fully the physical and mental status of disabled persons;

2. **Becoming acquainted with various rehabilitation opportunities, and**

3. Helping to bring about gainful employment and happy living for these folks.

It urges physicians to avail themselves of the various services obtainable in Wisconsin for the welfare of their patients. Who has better knowledge of handicapped persons and their requirements?

If the captain of the team is informed and cooperative, the goal can be attained.

NAME NEW FEDERAL NARCOTICS AGENT IN WISCONSIN

Drug Chief Lists Law Changes, "Don'ts" for MD's to Follow

MILWAUKEE—Wisconsin's new federal narcotic agent is George Emrich, who succeeded Owen Lewis this fall. His office is in Room 709, Federal Bldg., 517 E. Wisconsin Ave., Milwaukee 1. His telephone number is Broadway 2-8600.

Emrich, a native of Denver, served nine months in the FBI identification division in Washington, following 51 months service in the U.S. Navy. In 1948 he was appointed as a narcotic agent in Chicago and held that position until named to the Wisconsin office.

The new chief is 31, and the husband of a registered nurse who practiced her profession in Richmond, Va.

Lewis, now a Madison resident, served 30 years as a district supervisor and narcotic agent for the Federal Bureau of Narcotics. His efforts merited high praise from Bureau officials, law enforcement officers and physicians.

A. E. Aman, Chicago, district supervisor in Illinois, said of Mr. Lewis:

"He was one of the outstanding agents of the Bureau, on registrant work as well as criminal investigation. In his present capacity as an investigator for the State of Wisconsin relative to nurses' registration, he will be of great value to that organization as well as to the State."

M. D. ROLE VITAL

Emrich is convinced that the physicians' role in narcotic law enforcement is extremely important. He said:

"The physician who is aware of the narcotic law and his obligation thereunder can be of great help to enforcement officers. I'd suggest physicians become familiar with the following 'don'ts':

"1. Don't leave prescription pads around, since addicts want them in order to effect narcotic forgeries.

"2. Don't write a prescription for narcotics in pencil. Try to avoid writing any prescription in pencil. Many are changed to call for morphine or other narcotic drugs.

"3. Don't write for narcotics in this manner: Morphine HT ½ #X or Morphine HT ¼ #10. Several X's or zeros can be added to raise the amount. Use brackets or spelling to insure against changing of amounts.

"4. Don't carry a large stock of narcotics in your bag since addicts are always on the lookout for these in doctor's offices and automobiles.

"5. Don't store your office supply of drugs where patients may have access to them, such as near a sink or urinal. Patients may ask to use these.

"6. Don't fall for a good story from a stranger claiming an ailment that usually requires morphine or other narcotic drugs. The addict can produce bloody sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

"7. Don't write a narcotic prescription to another without seeing the patient. Addicts have posed as nurses to get doctors to prescribe narcotics.

"8. Don't write for large quantities of narcotics unless unavoidable. Diversion to addicts is a profitable business, as much as $1 for ½ grain Morphine Sulphate.

"9. Don't prescribe narcotics on the story that another M. D. had been doing so. Consult that physician or the hospital records whenever possible.

"10. Don't leave prescription forms signed in blank at the office for nurses to fill in. Signed blanks are bad practice and many have been stolen by addicts.

"11. Don't treat an ambulatory case of addiction. They must be under proper control. Addicts will go to several physicians at a time. Notify your local police or this Bureau.

"12. Don't dispense any narcotics without keeping a record of it. Bedside and office administrasion is permitted without record.

"13. Don't buy your office narcotic needs on a prescription blank. The law requires you use an official order form.

"14. Don't resent a pharmacist's call for information concerning a prescription you may have written. He is held responsible for filling forgeries. Please cooperate in this matter.

"15. Don't hesitate to call the U.S. Bureau of Narcotics, Treasury Dept., in Milwaukee, to obtain or to give information. Everything you say will be held strictly confidential."

Emrich particularly advised physicians to avoid ordering narcotics in quantity.

"Large narcotic stocks represent considerable value to the addict or peddler, and therefore represent 'break-in-damage' or physical harm to the doctor," the agent warned.

"The transient addict is a problem for both the practitioner as well as the enforcement officer and both must be on the alert for him. In event you become suspicious of anyone attempting to obtain narcotics from you, or if you receive phone calls of questionable nature, call your local police or the sheriff's office at once. They are near and available at all times."

(Continued on page 1382)

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

U. S. PUBLIC HEALTH SPENDING KEEPS CLIMBING

COST TO AVERAGE $15.17 FOR EACH PERSON IN U. S. A.

WASHINGTON, D.C. — During the current fiscal period, federal spending for health purposes will aggregate $2,558,719,168, compared with expenditures of $2,268,826,576 in fiscal 1956.

The Washington AMA office said the report dealt only with money that has been appropriated, and currently is available to be spent.

Here are some conclusions:

1. *It is costing each man, woman and child in the United States $1.78 more this year than last for federal spending in health and medical fields.*

$38.72 EACH

2. If only wage-earners are considered, they will be paying an average of $38.72 each to finance the government program. This is $4.40 more than last year.

3. The average family cost will be $54.61 this year.

4. The current fiscal figure is a billion dollars more than the cost of running the Commerce Department, half a billion more than all Agriculture Department expense and six times the budget of the Interior Department.

5. *Mostly because of spectacular increases for research, health programs of the Department of Health, Education and Welfare this year, the cost will be 50 per cent above last year.*

VA ATOP LIST

6. For the first time since World War II, medical costs of the Veterans' Administration top the list, passing the Defense Department. A close third is HEW. The figures respectively: $825,024,300; $790,105,000 and $772,661,800.

HEW is spending more for its division of hospital facilities, for its Hill–Burton program, the National Institute of Health, the Nation Cancer Institute, the National Heart Institute, Mental Health Institute, Arthritis and Metabolic Diseases Institute, Neurological Diseases and Blindness Institute.

Allergy and Infectious Diseases Institute, Dental Health Institute, National Institutes of Health–General Funds, Indian health activities, hospitals and medical care, tuberculosis control, sanitary engineering activities, communicable disease control, venereal disease control, foreign quarantine service, office of the surgeon general;

Alaska-disease and sanitation investigations and control, social security administration, bureau of public assistance, children's bureau and the office of vocational rehabilitation.

It is spending the same as last year for research and reimbursable health programs for other government agencies.

INCREASE NOTED

New categories in 1957 include NIH planning and construction, water pollution control, the National Library of Medicine and the Alaska Mental Health program.

In the VA budget, showing increases were in-patient care in VA hospitals, modernization and replacement construction, domiciliary care, medical research; major alterations, improvements and repairs; supply depot operations and medical education and training.

MEDICAL–HEALTH BUDGETS OF FEDERAL DEPARTMENTS, AGENCIES AND COMMISSIONS FOR THIS FISCAL YEAR

Agency	*Fiscal 1957*	*Fiscal 1956*
Veterans Administration	$ 825,024,300	$ 790,185,800
Department of Defense	790,105,000	818,104,500
Department of Health, Education and Welfare	772,661,800	526,935,400
Federal Civil Defense Admin.	49,810,000	30,450,000
Atomic Energy Commission	31,525,000	27,700,000
International Cooperation Admin.	29,310,000	25,441,000
Department of State	15,496,000	13,669,790
Federal Employees Health Program	10,000,000	6,000,000
National Science Foundation	8,000,000	5,000,000
Department of Labor	7,151,126	7,336,000
Department of Interior	6,138,205	5,770,000
Panama Canal Zone	6,055,300	5,702,900
Department of Treasury	3,511,700	2,990,000
Department of Justice	1,580,000	1,470,000
Federal Trade Commission	1,000,000	1,000,000
Department of Commerce	547,914	277,586
Civil Service Commission	386,000	382,600
National Advisory Committee to Selective Service	180,000	180,000
President's Comm. for Handicapped	134,678	130,000
Health Resources Advisory Comm.	90,000	101,000
Office of Attending Physician of Congress	12,145	
Totals	$2,558,719,168	$2,268,826,576

DISK JOCKEYS HELP POPULARIZE SALK

RALEIGH, N. C. — The North Carolina Medical Society reported recently it had enlisted the aid of radio disk jockeys in an effort to get teen-agers down to the doctors' offices for Salk polio vaccine shots.

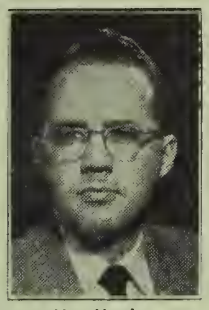
The Society's suggested pitch was this:

"Walk with Salk, so you can rock 'n roll."

As one of the disk jockeys commented, this should make the youngsters *"dig out for some of that 'crazy' vaccine."*

DOCTOR!

There's still time to sign up for the First Annual Wisconsin Physicians' Bowling Tournament, to be held in Wisconsin Rapids, Feb. 2. You and your lady are welcome—and urged to take part. Stress will be on *fun* and *good fellowship*. The Wood County Medical Society will be host at a party following the pin-blasting. Just drop a card to State Medical Society (Bowling), Box 1109, Madison, and you'll be all set to roll 'em! But please, do it now!



Mr. Hughes

L. L. HUGHES GETS U.W. HOSPITAL POST

MADISON—For the first time in the history of the University of Wisconsin Hospitals, a man has been named to the superintendency who is not a physician.

The Wisconsin Board of Regents recently appointed **Lloyd L. Hughes**, Providence, R. I., to succeed **Dr. Harold M. Coon**, who accepted a post as Milwaukee County Hospital administrator, effective Feb. 1.

Hughes has been assistant director of the Rhode Island Hospital, also serving as director of personnel and public relations for that institution.

DR. GAVIN CITED AT N. C. CONFERENCE

ST, PAUL, MINN.—Dr. S. E. Gavin, Fond du Lac, was cited as one of the founders of the North Central Conference at an annual meeting of the group in November.

The citation read:

"This . . . is presented to Dr. Gavin in grateful recognition of his contribution to the welfare of medicine and of the valuable service he has performed as one of the founders of this Conference."

The organization was created in 1947.

Dr. R. G. Mayer, Aberdeen, S. D., was elected president-elect and R. R. Rosell, executive secretary of the Minnesota State Medical Association, reelected secretary-treasurer.

This year's session was devoted to discussions of medical ethics, relationship of physicians to Blue Shield, the military dependents medical care program, activities of the World Medical Association and legal considerations of medical practice.

MACHINIST STARTS SUIT AGAINST FROMMES: BLAMES WOES ON HORMONE

MILWAUKEE—A one million dollar lawsuit was filed in federal court here Oct. 30 by a Milwaukee machinist who charged that treatments he had received from a scalp specialist caused him to develop some feminine physical characteristics.

Joseph McGuire, 47, a bachelor, sued Frommes Method Inc., Minneapolis, and Frommes Hair and Scalp Specialists, Milwaukee.

McGuire charged the defendants with "grossly negligent use of estrogen hormone" rubbed into his scalp. He said he had a bald spot.

One of the "physical changes" which he cited was "enlargement of the breasts." This, he contended, caused him embarrassment among fellow employes and "great ridicule," because he had to change clothes at the machine shop where he worked. He said he finally quit his job.

CONDITION PERMANENT?

Atty. James Cannon, McGuire's counsel, said the breast enlargement was "very noticeable."

The suit charged that McGuire had suffered "great psychological shock, embarrassment, loss of his position and livelihood and great apprehension that his condition is permanent in nature."

According to the complaint, McGuire began taking scalp treatments Jan. 16, 1956. He continued them until Aug. 13 at a cost of $505.

McGuire, who is 5 feet, 10 inches tall and weighs 182 pounds, came to Milwaukee from Youngstown, O., in 1949.

"In July, 1956, the plaintiff became nervous and noticed definite physical changes in his body," the suit stated.

Cannon wrote in the complaint: "Upon my advice, the plaintiff consulted an internist who examined him and who then requested a consultation with an endrocrinologist.

NEGLIGENCE CHARGED

"The condition was diagnosed as gynecomastia, or enlargement of the breasts.

"There was no metabolic abnormality to account for this condition, and the cause was the negligent and excessive use of estrogen containing medication absorbed by the scalp of the plaintiff during the course of treatment with Frommes."

In an interview with a Milwaukee Journal reporter, Carl Bolin, manager of the Frommes Clinic in Milwaukee, said he had "no idea what was in the formula." He said the scalp treatment was sent here from the Minneapolis plant.

Bolin also said that others had been treated the same way as McGuire, but that he had never heard of any such similar incident or reaction.

A spokesman for the Frommes firm in Minneapolis said the company had received correspondence in the McGuire case but did not know a suit had been filed and had not been served. Leo N. Fromme, president, was not available for comment.

Hospitalization and Births at Record Rate in 1955

CHICAGO — Hospitals in the United States cared for 21,072,521 patients in 1955, a record high, the American Hospital Association reported recently.

The total was 20,345,431 in 1954.

Hospital births totalled 3,476,753, a rise of 134,154 over the previous year.

On an average day, there were 1,363,024 patients and 49,467 newborn infants in the hospitals last year.

Total 1955 payroll for all hospitals was $3,581,784,000 for 1,300,733 fulltime employees.

Other A.H.A. figures:

More than 290,000 professional nurses provided services in hospitals in 1955.

Average hospital stay was 7.8, same as in 1954.

Assets of all hospitals totalled $11,986,126,000.

95 per cent of all admissions last year were to general hospitals.

38 per cent of all hospitals had less than 50 beds, 14 per cent had more than 300.

50 per cent of all hospitals were non-profit; 18 per cent proprietary and 32 per cent operated by federal, state and local agencies.

JOB PLACEMENT . . .

(Continued from page 1375)

electroencephalograph technician, chief medical technologist, medical technologist, bacteriology technician, biochemistry technician, hematology technician, serology technician and tissue technician.

No fee is charged for the service.

The district offices are located in the following cities:

Appleton, Ashland, Beaver Dam, Beloit, Eau Claire, Fond du Lac, Green Bay, Janesville, Kenosha, La Crosse, Lancaster, Madison, Manitowoc, Marinette, Milwaukee,

Neenah, Oshkosh, Racine, Rhinelander Sheboygan, Stevens Point, Superior, Watertown, Waukesha, Wausau and Wisconsin Rapids.

Setting up the employment program was the Assistant Society's first project. The group was organized only 18 months ago.

NARCOTICS . . .

(Continued from page 1379)

Emrich called attention to several changes in penalty provisions of the Narcotic Control Act of 1956, which became effective July 19. These changes include:

1. Minimum 10-year mandatory sentence with possible death sentence at the discretion of the jury for the unlawful sale of Heroin by a person over 18 to a person under 18. There also is provided for the same type of violation when it involves narcotic drugs other than Heroin, or Marihuana, a penalty of not less than 10 years or more than 40 years. A fine of not more than $20,000 may also be imposed in both instances cited in this revision.

2. Penalties for all other sale offenses and those involving illegal importation or smuggling of narcotic drugs or Marihuana are for a first offense, not less than five years nor more than 20 years. For a second or subsequent offense, not less than 10 years nor more than 40. In both instances, a fine of $20,000 may be imposed.

3. The penalties for so-called possession or other type of offenses are: for a first offense, not less than two years nor more than 10; for a second offense, not less than five years nor more than 20; and for a third and subsequent offense, not less than 10 years nor more than 40. A fine of $20,000 may be imposed in each conviction. Probation, suspension or sentence or parole may be granted only if conviction is for a first offense.

State Board of Health Cites Need Of More Personnel

MADISON—The State Board of Health 1957–59 budget is seeking an additional appropriation of $380,500 for urgently needed personnel.

The Board said it needed public health physicians for district offices in Fond du Lac, Madison and Rhinelander; an epidemiologist; an administrative assistant; two dental hygienists; a graduate nurse; milk sanitarian; four public health engineers and a public health educator.

There also is an urgent need, the Board said, for establishment of a special unit to promote prevention and reduction of chronic disease. The increasing number of aged persons in Wisconsin, coupled with the anticipated results of stepped-up research into the nature, causes and control of such diseases, was the basis for the Board's action.

S.M.S. GETS CHEESE TRAY

MADISON—An unusual cheese tray, the original of which he saw in Monaco, has been presented to the State Medical Society by Dr. R. G. Arveson of Frederic.

On his trip to Europe last spring, Dr. Arveson spotted the tray in a small restaurant and quickly jotted down the design. Made of rock maple, one of the hardest woods in America, it consists of a square surface with two jutting handles for carrying purposes.

QUITE A JOB!

"I had trouble running the saw through this hard wood," Dr. Arveson said. "We finally got this licked and then the handles were glued together and put on."

NOTE!

A map showing the location of the S.M.S. building and other health and medical spots in Madison is available. Just drop a request to the S.M.S. and one will be sent to you promptly.

CURING FEAR

One of the weaknesses of this generation is fear. Fear of atomic destruction, fear of cancer, fear of heart attacks, and other fears daily plague the minds of our people. Unless checked, this fear-complex may cause untold harm. As counselors, physicians have an excellent opportunity to combat this epidemic of fear. In the office, at the bedside, through health forums, radio programs, TV shows, and emergency services doctors can alleviate to a great extent fear of dreaded diseases and sudden sickness.

Quoted from Dr. Dan Mellen, President, Medical Society of the State of New York.

Help Fight TB

Buy Christmas Seals

Doctor!

Have you sent your contribution to the Society's Charitable, Educational and Scientific Foundation, Inc.?

Name Dr. Gundersen To W.M.A. Council

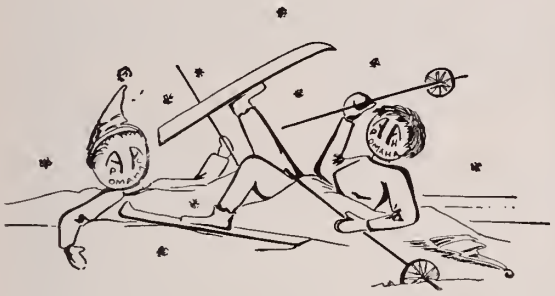
HAVANA, CUBA—Dr. Gunnar Gundersen, La Crosse, Wis., was elected to the Council of the World Medical Association at its 10th General Assembly this fall.

He was named for a term expiring in 1959.

A.M.E.F. REPORTS CONTRIBUTIONS

CHICAGO—The American Medical Education Foundation reported the following contributions in November:

Dr. John M. Bell, Marinette, $500; Dr. S. E. Gavin, Fond du Lac, $50 and The Wisconsin Society of Anesthesiologists, $50.



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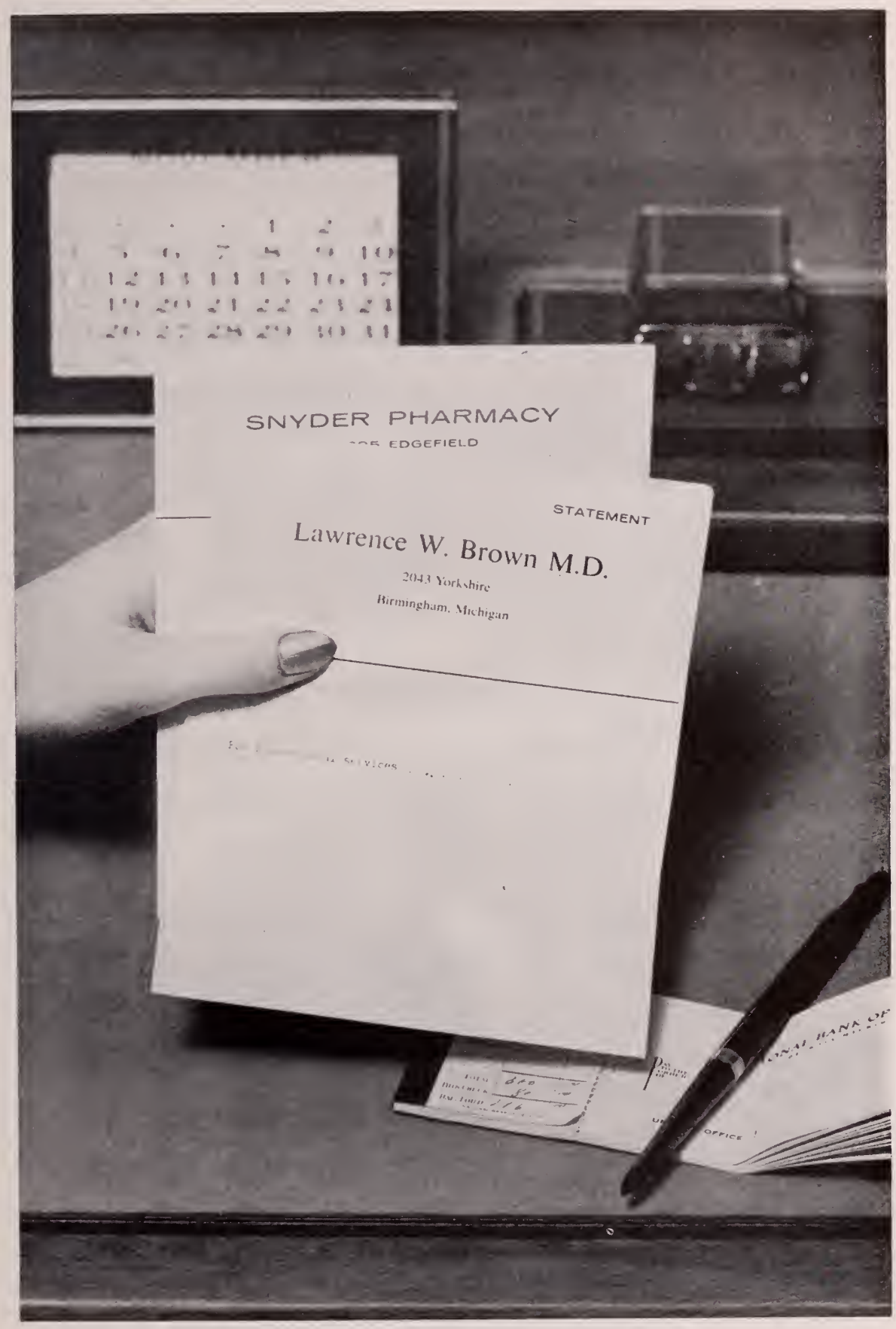

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/s/ ADELE G. STAHL, R. N., *Director*
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INDEX TO ADVERTISERS

	Page
Abbott Laboratories	1290, 1291
Ames Company, Inc.	1399
Ayerst Laboratories	1383
Barr X-Ray Company	1390
Benson Optical Company	1360
Brown and Williamson Tobacco Corp.	1297
Burroughs Wellcome & Co., Inc.	1289, 1358, 1359
Chicago Medical Society	1364
Ciba Pharmaceutical Products	1367
Coca-Cola Company	1362
Cook County Graduate School of Medicine	1374
Corn Products Company	1284
Davies, Rose & Co., Ltd.	1365
Doerflinger Artificial Limb Co.	1390
Endocrine Laboratories	1357
Foot-so-Port Shoe Company	1372
Hotel Schroeder	1386
House of Bidwell	1367
Hurley X-Ray Company	1386
Keeley Institute	1374
Kennedy–Mansfield	1371
Lakeside Laboratories	1294, 1372, 1389
Lederle Laboratories	1334, 1335, 1361, 1389
Lilly, Eli and Company	1302
Linde Air Products	1365
Mallard, Incorporated	1389
Mallatt Pharmacy	1371
Mather Pharmacy	1371
Medical Protective Company	1390
Merck, Sharp and Dohme	1286, 1287, 1298, 1368, 1369, 1391
Milwaukee Sanitarium Foundation, Inc.	1400
New Orleans Graduate Medical Assembly	1281
New York Polyclinic	1280
Orthopedic Appliance Company	1374
Parke, Davis and Company	1278, 1279, 1384, 1385
Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc.	1282, 1283, 1292, 1293
Physicians Casualty Association	1383
Pogue, Mary, School, Inc.	1280
Professional Business Service	1379
Quincy X-Ray and Radium Laboratories	1374
Rennebohm's	1371
Riker Laboratories, Inc.	1296
Rogers Memorial Sanitarium	1400
Sacred Heart Sanitarium	1370
St. Croixdale Sanitarium	1281
Schering Corporation	1300, 1301
Schieffelin and Company	1357
Schmid, Julius, Inc.	1288
Searle, G. D. and Company	1355
Shorewood Hospital Sanitarium	1363
Smith, Kline & French Laboratories	1285, 1356
Time Insurance Company	1377
Upjohn	1387
Wallace Laboratories	1392
Wine Advisory Board	1299
Winthrop Laboratories, Inc.	1295, 1373
Wisconsin Neurological Foundation	1366

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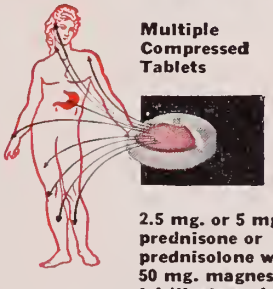

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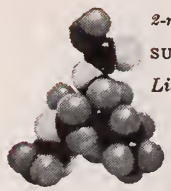

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INDEX

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VOLUME LV

JANUARY 1956–DECEMBER 1956

INDEX VOL. LV, 1956

Authors

	Page
Althaus, C. F., Sunnyvale, Calif.	823
Ansfield, Fred J., Glidden	431, 1319
Ausman, R. K., Milwaukee	636
Babbitt, D. P., Milwaukee	815
Barrow, D. W., Milwaukee	732
Barrock, James J., Milwaukee	977
Beckman, Harry, Milwaukee	174, 277, 396, 532, 641
Benjamin, H. B., Milwaukee	636
Betlach, Dorothy W., Janesville	452, 833, 1321
Bonica, John J., Tacoma, Wash.	387
Bourne, N. W., Milwaukee	815
Campbell, R. E., Madison	1079
Clatanoff, Dallas V., Madison	521
Cleveland, David, Milwaukee	528
Conway, James P., Milwaukee	428
Crepea, Seymour B., Madison	836, 988
Davis, Milton, Jr., Madison	1094
Davis, V. Terrell, Trenton, N. J.	621
Dickie, Helen A., Madison	433
Doberneck, R. I., Milwaukee	732
Erchul, J. W., Monroe	319
Evans, James A., Boston, Mass.	267
Farmer, Silas, Racine	968
Feig, Milton, Madison	462
Filek, Allan, Madison	306
Ford, John L., Green Bay	191, 533
Fox, Max J., Milwaukee	972
Freeman, D. Joe, Madison	709
Froehlich, Ernst M., Milwaukee	1203
Glassy, F. J., Marshfield	1197, 1212
Greenberg, A. I., Milwaukee	1219
Haukohl, Robert S., Milwaukee	455
Heise, Leonard, Madison	837
Hittner, Vernon J., Seymour	533
Holbrook, A. A., Milwaukee	304
Jaeck, James L., La Crosse	543
Jaeschke, Walter H., Madison	642
Jorris, E. H., Madison	647
Kearns, Walter M., Milwaukee	159, 726
Kiekhofer, William, Madison	1079
Kinross-Wright, Vernon, Houston, Tex.	1073
Kuzma, J. F., Milwaukee	636, 828
Llewellyn, M. B., Janesville	989
Lubitz, Joseph M., Wood	1097
MacCornack, R. L., Jr., Whitehall	1197
Mann, Robert, Milwaukee	636
Marquardt, C. R., Milwaukee	630
Maxwell, Ned G., Milwaukee	1183
McIntosh, James F., Madison	825
Meyer, Ovid O., Madison	521
Middleton, William S., Washington, D. C.	1189
Muegge, O. J., Madison	744
Nesbitt, Tom E., Milwaukee	815
Noe, Theodore, Madison	197
Olson, E. S., Racine	738, 968, 1315
Pawsat, E. H., Fond du Lac	820
Pica, Vincent B., Milwaukee	972
Pick, J. W., Milwaukee	630
Regan, Louis J., Los Angeles, Calif.	25
Rens, John L., Phillips	1319
Sanders, Luida E., Madison	998
Santer, D. G., Milwaukee	726
Sargent, James W., Milwaukee	965
Sattler, Marvin E., Milwaukee	722, 1219
Schruempf, Edmund W., Milwaukee	1203
Segnitz, Richard H., Milwaukee	447, 1197
Shapiro, Walter D., Milwaukee	272
Shideman, F. E., Madison	742, 836, 988, 1105, 1208
Shields, G. G., Wisconsin Rapids	1104
Shinners, G. M., Green Bay	1324
Simenstad, L. O., Osceola	617
Sims, J. L., Madison	1105
Smith, Ralph E., Minneapolis, Minn.	272
Spengler, John R., Madison	167
Spolyar, Louis W., Indianapolis, Ind.	984
Sproule, Ralph P., Milwaukee	536
Steffen, Elizabeth Allen, Racine	1303
Swart, Robert E., Hayward, Calif.	528
Taylor, Robert D., Marshfield	162
Thatcher, Donald S., Milwaukee	1306
Thewlis, Ethel W., Madison	521
Van Duser, A. L., Madison	542, 1202
Wagner, Marvin, Milwaukee	636
Welton, David Goe, Charlotte, N. C.	170
Wilkie, James M., Madison	167
Willson, D. M., Milwaukee	726
Wood, Everet H., Madison	1086
Wynn, Sidney K., Milwaukee	428
Zeit, Walter, Milwaukee	636

Articles

	Page
Abortifacients, Sale of contraceptives and	62
Abortions, Legal aspects of	59
Acne Vulgaris in teen-age males, The failure of testosterone lotion to aggravate, Holbrook	304
Adoption, Physicians and child placement	49
Adrenal Cortical Insufficiency	1321
Advertisers, Index to	134, 246, 362, 494, 588, 682, 782, 930, 1037, 1146, 1272, 1390
Afibrinogenemia after cesarean section, Fibrin emboli of the lungs with, without the presence of amniotic epithelial squames	1315
Allergic Reactions to contrast medium with Chlor-Trimeton, Prevention of, Kearns	159
American Medical Association, principles of medical ethics	111
Anesthesia, Increasing the safety of obstetric	1094
— in patients with intestinal obstruction	452
— in surgery, obstetrics, diagnosis, and therapy, The role of regional, Bonica	387
— study commission	452, 833, 1321
Aneurysm of the aorta, The prognosis in dissecting—therapeutic suggestion, Freeman	709
— Ruptured intracranial, a case report, Cleveland and Swart	528
Anuria, The problem of acute, Willson, Kearns, and Santer	726
Asthma, The symptomatic treatment of bronchial	988
Atresia of the posterior nares, Congenital bilateral bony, Wynn and Conway	428
Autohemotherapy—An effective treatment for herpes zoster, Ansfield and Rens	1319
Bacteroides Fragilis, Case report of a fatal infection with, Froehlich and Schruempf	1203
Basic Sciences, State board of examiners in	69
Blood Test, Identification by	50
Blood Vessels, interpolated vascular grafts	636
Blue Cross for physicians, Blue Shield and	23
Blue Shield and Blue Cross for physicians	23
Board of Health	68
— As it looks to your	197, 306, 462, 542, 647, 744, 837, 998, 1104, 1202, 1324

Book Reviews

	Page
Alimentary tract, Bickham-Callander surgery of the	581
Allergy, Practice of	677
Biochemistry, Clinical	1264
Cancer, The truth about	1022
Cardiology, Correlative: An integration of cardiac function and the management of cardiac disease	779
Clinical diagnosis	584
Cold environment, Man in a; physiological and pathological effects of exposure to low temperatures	126
Current therapy 1955	584
Drug therapy, Reactions with	1264
Emotions and bodily changes	581

Page

Fevers, Prolonged and perplexing 583
Fluoroscopy in diagnostic roentgenology 679
Fracture treatment, Illustrated review of 129
Galen of Pergamon 584
Goiter, Endemic 126
Heart and circulation and its clinical application in physical medicine, Physiology of 779
Infectious disease, its origins and conquest, Pomp and pestilence 677
Ion exchange and adsorption agents in medicine; the concept of intestinal bionomics 130
Medical treatment, Handbook of 125
Medicine, A synopsis of 126
Microbiology, Review of medical 125
Minds go wrong, When 677
Nervous system, Clinical aspects of the autonomic 678
Nutrition and metabolism, Standard values in 243
Pace is not killing us, This 1264
Peripheral vascular diseases 124
Physiology, A textbook of 125
Public relations in medical practice 583
Reproductive system 243
Story of you, The 581
Urology, Volume One 124
Urology, Volume Two 124
Urology, Volume Three 124
Bowel Obstruction, Unusual manifestation of Weber–Christian disease, Sattler and Greenberg 1219

Cancer at University Hospitals, 1946–1955, Gynecologic 1079
— Climate and cutaneous, Welton 170
— Doctors plan war on uterine 1202
Carcinoma of the thyroid, MacCornack, Glassy, and Segnitz 1197
Cardiac Arrest, Barrow and Doberneck 732
Case Records and x-rays, Discarding 38
— The confidential nature of hospital 39
Cesarean Section, Fibrin emboli of the lungs with afibrinogenemia after, without the presence of amniotic epithelial squames 1315
Child Placement, Physicians and 49
Chloramphenicol, a report of 6 cases treated with, The treatment of hemophilus influenzae, type b meningitis 820
Chlorpromazine jaundice 1105
Chlor–Trimeton, Prevention of allergic reactions to contrast medium with 159
Civil Defense—mobile medical teams, Noe 197
Clinicopathologic Conference 191, 319, 455, 543, 642, 738, 828, 989, 1097, 1212
Cold and its treatment, The common, Sproule 536
Comments on Treatment 174, 277, 396, 532, 641, 742, 836, 988, 1105, 1208
Contraceptives and abortifacients, Sale of 62
Contrast Medium, Hypaque Sodium, A new urographic 815
— with Chlor–Trimeton, Prevention of allergic reactions to 159
Correspondence 344, 489, 1386
Cryptorchidism, The management of, McIntosh 825
Cyst, Pancreatic, Internal drainage by the Roux-en-Y technique 722

Deadlines and other "musts", Your 63
Death Certificates 61
Dermatitis, Cold wave, complications and treatment, Barrock 977
Diabetes, Control of 1104
Disability Program aids 259 physicians 24
Diverticulum, Meckel's, Althaus 823

Eczema Vaccinatum, Treatment of by specific gamma globulin, Fox and Pica 972

Editorials

Aging, Let's focus attention on needs of the 1002
Annual meeting survey, Surprising results 1001
"Cultists, expediency, and responsibility" 467
Dependent's day 203
Dependents' Medical Care Plan 1351
Horsepower or horse sense 204
Hoxsey hoax 659
Integrity, Applied 840
Information, please 80
Interprofessional cooperation 324
Library for medicine, A 746
Medical examiners, Functions of the state board of 1120
Physician, The best 1352
Polls and public opinion 323
Professional integrity and responsibility 839
Program, A valuable 468
Response, A gratifying 746
Rural health, Thoughts on 1226
Scientific articles 203
Social security expansion, Press reaction to 1003
To everything there is a season 552

Page

TB in state and county hospitals for the mentally ill 79
Up and still upward 468
Washington forecast 1352
Wisconsin diagnostic center, The 659
Emboli, Fibrin, of the lungs with afibrinogenemia after cesarean section, without the presence of amniotic epithelial squames, Olson 1315
Employee health services, Filek 306
Epileptics and the State Motor Vehicle Department 64
Esophageal Stenosis, Treatment of a five-pound infant with congenital, Segnitz 447
Ethics, Principles of Medical, American Medical Association 111
Eye, Foreign bodies in the 1086

Fee Splitting 41
Foreign Bodies in the eye, Wood 1086

Gamma Globulin distribution, Current policy for 542
— in treatment of epidemic infectious hepatitis, Ansfield 431
— Treatment of eczema vaccinatum by specific 972
Grafts, Interpolated vascular, Benjamin, Wagner, Mann, Zeit, Kuzma, and Ausman 636
Gynecologic Cancer at University Hospitals, 1946–1955, Kiekhofer and Campbell 1079

Health Officers, Services of district 1324
Hemophilus Influenzae, type b, meningitis, The treatment, of; a report of 6 cases treated with chloramphenicol, Pawsat 820
Hepatitis, Gamma globulin in treatment of epidemic infectious 431
— transmitting potential of plasma, A study of the control of the 1183
Herpes Zoster, Autohemotherapy—An effective treatment for 1319
Highway Safety is a health problem, too 998
Hospital Case Records, The confidential nature of 39
Hypaque Sodium, a new urographic contrast medium, Nesbitt, Bourne, and Babbitt 815
Hypertension, Management of essential, Taylor 162
— Modern management of the hypertensive patient, Evans 267

Industrial Commission, Wisconsin 69
Intestinal Obstruction, Problems in, in the neonatal period, Thatcher 1306
Intoxication, Chemical tests for 64
Inversion of Uterus, Puerperal 1303

Jaundice, Chlorpromazine 1105
Journal Bookshelf, *See* "Book Reviews"
Jury Duty, Physicians' exemption from 37

Laboratory of Hygiene, Instructions for the use of Wisconsin State 67
Lake Tomahawk State Camp, A look into the future at 837
Leukemia with a prolonged preleukemic phase, Chronic granulocytic, Clatanoff, Thewlis, and Meyer 521
Licensing, The unlicensed physician 33
Licentiates, Recent Wisconsin 240, 1370

Malpractice and the physician, Regan 725
"March of Medicine," Schedule of programs of the 40, 531, 629, 824, 987, 1085, 1314
Maternal Mortality Survey, Progress report on the Wisconsin 315
Medical Examiners, State board of 69
Meningitis, The treatment of hemophilus influenzae, type b 820
Mentally Ill, Tuberculosis in state and county hospitals for the 79

Narcotics Regulation, Physicians reminded of 648
Nares, Congenital bilateral bony atresia of the posterior 428
Nervous Conditions, The uses and limitations of the newer drugs in the treatment of 1073
Newborn Infant, Problems in intestinal obstruction in the neonatal period 1306
— Resuscitation of the 833

Obstetric Anesthesia, Increasing the safety of, Davis 1094

Pancreatic Cyst, Internal drainage by the Roux-en-Y technique, Sattler 722
Paratyphoid Fever, Typhoid and 968
Patient's Privilege 34
Phallus, Extragenital, case report, Hittner and Ford 533

Page

Physicians' Exchange ---133, 244, 360, 492, 586, 680, 780, 928, 1034, 1145, 1268, 1388
Plasma, A study of the control of the hepatitis-transmitting potential of, Maxwell ---1183
Poisons, Clinical memorandum on economic ---620
Polio Vaccine in Wisconsin, The effectiveness of Salk ---462
Postmortem Examination ---60
Privileged Communications ---34
Pseudohermaphroditism, extragenital phallus ---533
Public Welfare, State board of ---69

Rehabilitation Services in Wisconsin ---76
Restaurant Sanitation ---647
Resuscitation of the newborn infant ---833
Rhinitis, Symptomatic therapy of pollinotic ---836
Roux-en-Y Technique, Pancreatic cyst, Internal drainage by the ---722

Salk Polio Vaccine in Wisconsin, The effectiveness of ---462
Silver Nitrate, Physicians advised on substitution of ---66
Solvents, The commonly used toxic, Spolyar ---984
State Boards and Commissions, Officers of ---68

State Medical Society of Wisconsin

Annual Meeting, 1956 ---183-190, 278, 397-425
Annual dinner ---189
Exhibits
Scientific ---294, 411
Technical ---420
House of Delegates ---188
Program ---190, 400
Speakers ---184
Woman's Auxiliary ---188, 300, 417
Annual Meeting, 1957, preliminary announcement 1325
Exhibits, Scientific ---1326, 1327
Charter law of medical societies in Wisconsin ---100
Charitable, educational, and scientific foundation 22
Circuit teaching programs ---841, 997, 1091, 1227, 1318
Constitution and by-laws ---101
Council award, Recipients of the ---121
Council meetings, Minutes
February 25-26 ---1328
April 29 ---1336
July 28 ---1340
September 7-8 ---1346
October 27 ---1348
Councilor districts, Map indicating location of ---85
County medical societies, List of officers and scheduled meetings of ---137, 590, 1038, 1149, 1274
Disability program aids 259 physicians ---24
House of Delegates ---419
—— Attendance at, May 1, 2, and 3, 1956 ---904
—— Message to, Simenstad ---617
—— Transactions of the 1956 regular session ---843
Medical History, Gleanings from the section on ---1007, 1110, 1223, 1354
Members ---87
News Items and Personals ---224, 334, 476, 560, 670, 760, 918, 1012, 1128, 1230, 1362
Obituaries ---232, 340, 486, 577, 674, 768, 924, 1018, 1137, 1234, 1364
Officers and councilors ---82
Officers of sections ---136
Past presidents ---118
President's Page ---21, 200, 326, 469, 553, 748, 838, 1000, 1108, 1224, 1353

Society Proceedings

Ashland-Bayfield-Iron ---327
Brown-Kewaunee-Door ---206, 327, 554, 660, 1357
Calumet ---470, 660
Crawford ---206
Dane ---206, 1357
Dodge ---206
Eau Claire-Dunn-Pepin ---915
Fond du Lac ---327, 554, 660, 750
Grant ---206, 1019
Green ---206, 1228
Green Lake-Waushara ---209, 750
Jefferson ---209, 327, 470, 1228, 1358
Juneau ---328
Kenosha ---209, 328, 470, 554, 750, 1125, 1228
La Crosse ---209
Lafayette ---209, 660
Manitowoc ---210, 328, 554, 660, 1010
Marathon ---210, 750
Marinette-Florence ---210, 470
Milwaukee ---210, 328, 660
Oconto ---329, 1358
Oneida-Vilas ---213
Outagamie ---213, 329, 472, 554, 660, 750, 1228, 1358
Pierce-St. Croix ---215, 472, 554, 1229
Polk ---215, 329, 554, 662, 915, 1125, 1359
Racine ---215
Richland ---215, 329, 915, 1010
Rock ---216, 331, 662

Page

Rusk ---216, 662
Sauk ---216, 329, 472, 554, 1125, 1229, 1359
Trempealeau-Jackson-Buffalo ---331, 472, 554, 1229, 1359
Walworth ---216, 331
Washington-Ozaukee ---218
Waukesha ---218, 662, 1359
Waupaca ---331, 556
Winnebago ---218, 472, 662, 915, 1360
Wood ---218, 331, 474
American Academy of General Practice
Milwaukee Chapter ---474
Wausau Chapter ---664
American Academy of Obstetrics and Gynecology ---222
Association of Wisconsin Psychiatric Clinics for Children ---1127
Councilor Districts
First ---556
Ninth ---220, 662, 1360
Tenth ---1230, 1360
Thirteenth ---664
International College of Surgeons, Great Lakes Division ---557
Interstate Postgraduate Medical Association ---220
Milwaukee Academy of Medicine 220, 333, 556, 664, 1360
Milwaukee Neuro-Psychiatric Society ---333, 664, 1230
Milwaukee Oto-Ophthalmic Society ---333, 556, 664
Mississippi Valley Medical Society ---222
Section on Internal Medicine ---664
Section on Surgery ---664
Wisconsin Academy of General Practice ---1125
Rock County Chapter ---222
Southwest Wisconsin Chapter ---222
Tri-County Chapter ---222
Wisconsin Dermatological Society ---474
Wisconsin Society of Internal Medicine ---1229
Wisconsin Society of Public Health Physicians 1010
Wisconsin Surgical Club ---556
Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology ---1229
Wisconsin Urological Society ---664
Society Records ---329, 337, 484, 565, 672, 764, 922, 1016, 1132, 1233, 1363
Standing Committees ---83
Third and Twelfth Districts News ---226, 337, 479, 563, 671, 762, 921, 1015, 1130, 1232, 1362
Sterilization ---50

Testosterone Lotion, The failure of to aggravate acne vulgaris in teen-age males ---304
Thyroid, Carcinoma of the ---1197
Tranquilizing Agents ---1208
—— The uses and limitations of the newer drugs in the treatment of nervous conditions, Kinross-Wright ---1073
Triplets born to primigravida, Carter ---639
Tuberculin Tests: their importance in a state program of tuberculosis control, Dickie ---433
Tuberculosis control procedures, Participation of physicians in private practice in basic ---437
—— control, Tuberculin tests: their importance in a state program of ---433
—— in state and county hospitals for the mentally ill ---79
—— Therapeutic trends in lymph node, Spengler and Wilkie ---167
Typhoid and paratyphoid fever; report of six cases with one death, Olson and Farmer 968

Unemployment Insurance Tax, Employers of four or more subject to ---62
University Hospitals ---65
Ureteral Stone, The management of, Marquardt and Pick ---630
Urinary Tract, Trauma and the, Sargent ---965
Urographic Contrast Medium, Hypaque Sodium, a new ---815
Uterus, Puerperal inversion of the, Steffen ---1303

Vocational and Adult Education, State Board of ---69

Water Supply Safety, A quarter century of ---744
Weber-Christian Disease, Bowel obstruction, unusual manifestation of ---1219
Weil's Disease, Shapiro and Smith ---272, 532
Wisconsin Diagnostic Center, The development of the clinical program of the, Davis ---621
Wisconsin Interscholastic Athletic Association, Benefit programs of the ---71
Wisconsin Physicians Service, Facts about ---123, 249, 343, 464, 580, 668, 766, 927, 1009, 1136, 1266, 1350
Workmen's Compensation Act, Physicians and the ---42

X-Rays, Discarding case records and ---38

Zoonoses—a serious medical problem, Middleton 1189

1956 Medical Forum Index

ADOPTIONS, doctor's role in (part I) ____ 308
—— part II ____ 440
ADVERTISING by physicians, Council ok's policy on 1029
AGED, House gets new hospitalization plan for __ 574
AGING POPULATION, Governor's Conference on ___ 568
AMERICAN LEGION CAMP starts 31st year of service ____ 756
AMERICAN MEDICAL ASSOCIATION checks views on organized medicine ____ 311
—— Committee to draft law on labeling ____ 1237
AMERICAN MEDICAL EDUCATION FOUNDATION reports contributions ____914, 1235, 1382
—— reports Wisconsin contributions ____ 314
—— Wisconsin ranks 10th in gifts ____ 439
ANNUAL MEETING rated very well by exhibitors __ 1115
ARTHRITIS AND RHEUMATISM FOUNDATION, more than 7,000 register during drive ____ 911
ARTHRITIS BOOK, claims of "cures" by writer refuted ____ 1113
ARVESON, DR. R. G., gives cheese tray to S.M.S. 1382
—— honored at joint meeting of Commission on Medical Care Plans and general Council __ 1116
—— renamed Council chairman ____ 307
AUTO CRASH INJURIES, film available ____ 1117

BAHAMAS MEDICAL CONFERENCE, Wisconsin physicians invited to attend ____ 1115
BASIC SCIENCE EXAMS arranged for Madison and Milwaukee ____ 53
BERNHART, DR. E. L., re-elected president by Charitable, Educational, and Scientific Foundation ____ 567
BLUE CROSS membership now 50,179,264 ____ 312
—— Michigan, editorials defend, question current policies and rates ____ 570
—— Michigan, rate hike ok'd ____ 307
BLUE SHIELD–BLUE CROSS mobile trailer unit ___ 1117
—— public relations conference at U. W. ____ 908
BLUE SHIELD membership continues to rise ____ 912
—— 10th district reports plans for closer coordination ____ 651
—— physicians urged to enroll in plan ____ 1235
—— physician enrollment shows increase ____ 1235
BOARD OF HEALTH, Wisconsin visiting committee travels to Virginia and New York ____ 179
BOWLING TOURNAMENT for M.D.'s considered ___ 442
—— Announce plans for tourney in Wisconsin Rapids ____ 1242
BRASWELL, DR. H. M., comes to Wisconsin ____ 1375
BROWN–KEWAUNEE–DOOR MEDICAL SOCIETY, seek division of ____ 1028
BURNEY, DR. L. E., named surgeon general of U. S. Public Health Service ____ 1030

CAMBRIDGE DOCTORS build new clinic ____ 1118
CAMPBELL, MRS. CATHERINE K., resigns post as state school health consultant ____ 177
CANCER COMMITTEE health consultant spurs quackery fight ____ 1236
CANCER SMEAR TESTING, Dr. Stovall explains plan for 7 counties ____ 568
CANCER SURVEY, conducted by U. W. Tumor Clinic 1241
CASWELL, DR. H. O., Fort Atkinson honors ____ 913
CHARITABLE, EDUCATIONAL, AND SCIENTIFIC FOUNDATION INC. maps active future ____ 652
—— Loans microscope to medical student ____ 1242
CHILDBIRTH CLINICS acclaimed successful ____ 55
CHIROPRACTOR, Sheboygan man loses license ____ 1241
CIRCUIT TEACHING PROGRAMS to present clinical cases ____ 907
—— 12 scheduled ____ 752
CIVIL DEFENSE ORGANIZATION, annual conference of County Medical Societies ____ 1114
—— improvised hospital units ok'd ____ 1023
—— "operation alert 1956" proves successful trial 1025
—— physicians told to awaken to needs ____ 652
—— physicians' role in vital ____ 1024
—— roster of medical teams ____ 1026
CLINIC MANAGERS'–S.M.S. meeting acclaimed successful ____ 182
CORONER, doctors urged to run for post ____ 653
COUNTY MEDICAL SOCIETY ACTIVITIES, booklet available ____ 443

DANE COUNTY MEDICAL SOCIETY publishes newshandling guide ____ 653
DETERT, FLOYD, named clinic association head __ 1376
DIABETES COMMITTEE formed ____ 655
DISABILITY "FREEZE," clarify doctors' role ____ 751
DISABILITY INSURANCE (group) aided 15% of S.M.S. membership in 1955 ____ 441
DOCTOR DRAFT LAW predicted to end June 30, 1957 ____ 1028
DOPE ADDICTION, film offered ____ 658
DRUG DISTRIBUTION ____ 1030

EMRICH, GEORGE, named new federal narcotics agent for Wisconsin ____ 1379
EPPERSON, DR. E. P., named region I medical director for civil defense ____ 907

FAITH HEALER disclosed as fake in Madison ____ 53
FILEK, DR. ALLAN, gets national post ____ 571
FILMS added to A.M.A. library ____ 758
—— available ____ 1029
—— available from Abbott Laboratories ____ 446
—— food film available at A.M.A. office ____ 54
—— mental health films available at no cost ____ 446
—— oxygen therapy films offered ____ 442
FONS, DR. J. W., elected president, Medical Society of Milwaukee County ____ 51
FOOD FILM, available at A.M.A. office ____ 54
FOREIGN MEDICAL SCHOOL GRADUATES, A.M.A. trustees set up policy for evaluating ____ 751
—— state studies plan for screening ____ 175
FRANKFURTER, U. S. Supreme Court Judge Felix, hits "over-specialization" ____ 1240
FRED, E. B., urges U. W. med. students to learn human relations ____ 1241
FROMMES, sued for alleged negligence ____ 1381

GAVIN, DR. S. E., honored at St. Paul ____ 1381
—— renamed head of State Board of Health ____ 909
GRIEVANCE COMMITTEES guide booklet available _ 443
GROUP HEALTH FEDERATION OF AMERICA changes name ____ 1240
GUNDERSEN, DR. GUNNAR, named to W.M.A. Council ____ 1382

HALO ____180, 572, 656, 912
HAWAII MEDICAL GROUP to mark centennial ____ 182
HEALTH EDUCATION programs pay off ____ 574
HEALTH PROBLEMS, U. W. holds meeting on ____ 753
HEAR INC. aids physicians on hearing problems 908
HEIN, DR. FRED V., elected president-elect of school group ____ 58
HOBBIES, Wisconsin physicians have wide array _ 654
HOLLENBECK, DR. S. W., named vets' society treasurer ____ 913
HOSPITAL ACCREDITATION, A.M.A. report to be circulated ____ 1027
HOSPITAL CONSTRUCTION, State Board of Health votes approval for 19 ____ 443
HOSPITAL COSTS rising, wages cited as big item 439
HOSPITAL–PHYSICIAN SURVEY continues ____ 912
HOUGHTON, DR. J. H., named to Council ____ 1029
HOUSE OF DELEGATES, major actions during Annual Meeting ____ 567
HOWELL, DR. ERNEST C., named to Cancer Committee ____ 1237
HOXSEY CANCER "CURE" declared worthless ____ 572
—— remains a menace ____ 1376
HUGHES, L. L., gets U. W. hospital post ____ 1381

INDUSTRIAL GUIDE for M.D.'s and nurses revised 181
INSURANCE PLAN offers wide protection to homeowners ____ 1112
INTERNAL REVENUE CODE, Sen. Wiley asks changes in ____ 573
INTERPROFESSIONAL COOPERATION for improvement of our health and welfare, conference on 310

JOST, LEE, joins S.M.S. staff as fieldman ____ 1114

KASTEN, DR. H. E., named president-elect of S.M.S. ____ 567
KENOSHA COUNTY MEDICAL SOCIETY uses newsletter effectively ____ 441
KOEPP, DR. C. E., new A.M.A. alternate delegate 177

MASON, DR. P. B., appointed to district committee ____ 1029
MATERNAL MORTALITY STUDY COMMITTEE reports on progress ____ 655
MCROBERTS, DR. JERRY, elected president of State Board of Medical Examiners ____ 181
MEDICAL CARE PLANS, COMMISSION ON, Council, meet in joint session ____ 1118
—— discusses wide range of business, names officers ____ 754
—— executive committee continues study on special service contract benefits ____ 1118
MEDICAL CARE STANDARDS drafted for counties __ 58
MEDICAL EDUCATION, Ford grants $10 million ___ 569
—— wives' earnings help 18% of medical students through school ____ 914
MEDICAL EXAMINERS, STATE BOARD OF, cracks down on herb peddler ____ 911
—— groups work to improve licensing regulations 911
MEDICAL HISTORY, SECTION ON, M.D.'s invited to —— outlines plans for future ____ 655
MEDICAL MUSEUM, step closer to realization ____ 1375

Page

MEDICAL SCHOOLS, construction report ---- 1375
MENDOTA STATE HOSPITAL begins new residency program ---- 912
MENTAL HEALTH FILMS available at no cost ---- 446
MICHIGAN BLUE CROSS, editorials defend, question current policies and rates ---- 570
—— rate hike ok'd ---- 307
MILITARY DEPENDENTS' MEDICAL CARE, North Central Group meets to discuss ---- 1023
MILITARY to pay for emergency civilian care for servicemen ---- 1240
MURRAY, DR. DWIGHT H., urges improved doctor-public relations ---- 52

NARCOTIC LAWS, changes clarified ---- 52
NATIONAL RURAL HEALTH CONFERENCE in Oregon ---- 55
NEIDHOLD, DR. C. D., presents bloodletter to S.M.S. ---- 180
NEREIM, DR. T. J., named president-elect of W.A.G.P. ---- 1111
NURSING EDUCATION and training, changes urged 310
—— Illinois also has problems ---- 442
—— nursing program, U. W. professional, changed from 5 to 4-year course ---- 757
NURSING SURVEY to be ready this June ---- 445

OLSON, DR. M. H., reports on World Medical Association meeting ---- 443
—— to attend W.M.A. session ---- 1029
OPTICAL AIDS, state launches new program ---- 175
OPTOMETRY BOARD, legislative group to review rules and procedures ---- 572
OSTEOPATHS, House agrees it lacks power to admit to open panel program ---- 657
—— say A.M.A. ok needed to integrate MD's and 754
OUTAGAMIE COUNTY physicians and lawyers meet 312
OWEN builds clinic, gets new physician ---- 181
OXYGEN THERAPY, films offered ---- 442

PAMPHLET DISPLAY STAND available from Board of Health ---- 181
PECKHAM, DR. BEN M., gets U. W. medical school post ---- 444
PHYSICAL THERAPISTS, check on registration asked 751
PHYSICIANS FORUM again plugging for M.D. social security ---- 1113
PLYMOUTH PHYSICIANS build clinic ---- 445
POLIO, fight against wins results, battle not won 177
—— Propagandist, continue probation of ---- 1115
—— Vaccine, public clinics to get in March ---- 51
POMAINVILLE, DR. F. X., Council honors ---- 1029
POSER, DR. E. M., in 61st year of practice ---- 656
POSTGRADUATE MEDICAL EDUCATION, S.M.S. asked to correlate in Wisconsin ---- 653
POSTGRADUATE REFRESHER COURSES, expenses for may be deducted ---- 909
PRECEPTORSHIP PLAN enters 31st year at U. W. -- 178
PREMATURITY INSTITUTES planned for northern counties ---- 1377
PRENATAL FACT REPORTS, doctors asked to file -- 1238
PREPAID PLANS, M.D.'s advised to set average fees to further growth ---- 444
—— seek to pool resources in health insurance -- 907
—— study shows insured families incur higher charges for medical care ---- 914
PREPAID PLANS, COMMISSION ON—*see* "MEDICAL CARE PLANS, COMMISSION ON"
PSYCHIATRY TRAINING plan approved ---- 1236
PSYCHOLOGISTS, CLINICAL, state licensing of described as "unwise" ---- 656
P–R LEAFLET, "to all my patients," available at S.M.S. ----179, 655, 914

QUACKERY, forceful booklets on, available ---- 573

REHABILITATION, DIVISION ON, hears spokesmen for state agencies ---- 657
REHABILITATION, physicians' role detailed ---- 1378

Page

RESIDENTS, new deferment plan offered ---- 913
REUTHER, WALTER P., letter re Michigan Hospital Service Plan ---- 56

SAFETY BELTS, S.M.S. commission to work on development of high standards ---- 755
SALK VACCINE, disk jockeys help ---- 1381
SCHOOL HEALTH conferences scheduled ---- 569
—— proper medical testing insured at Oshkosh -- 573
—— state-wide meeting asked ---- 1240
SCHWADE, DR. E. D., wins Lennox award ---- 53
SHIDEMAN, DR. F. E., given honorary membership in S.M.S. ---- 443
SIMENSTAD, DR. L. O., honored at Osceola ---- 909
SMITH, DR. THEOBALD, bust to U. W. ---- 1381
SHORT TAKES ----180, 312, 444
SOCIAL SECURITY, administration voices strong dislike of H.R. 7225 proposal ---- 571
—— Council asks go-slow policy on changes ---- 307
—— disability payment measure opposed by Generalists ---- 573
STARKWEATHER, FRED, joins S.M.S. staff ---- 1238
STATE BOARD OF HEALTH, cites need of more personnel ---- 1382
STATE EXAMINER PLAN rapped by state crime laboratory director ---- 58
STATE MEDICAL SOCIETY, Council, Commission on Medical Care Plans meet in joint session -- 1118
—— executive committee of the general Council to continue study on constitution, by-laws 1117
—— 50-year club members honored ---- 572
—— new members briefed at Annual Meeting -- 652
—— on the calendar ----571, 655, 758, 907, 1027, 1118
—— special report on state meeting ---- 651
STATE NAUTICAL COMMISSION CREATED, doctor members ---- 1241
STOVALL, DR. WILLIAM D., named to State Blood Bank Association ---- 1235
STUDENT LOANS prove helpful ---- 1241

TELEVISION, color, to be featured at 1957 Annual Meeting ---- 1111
—— urge use at 1957 Annual Meeting ---- 754
TELEVISION-RADIO, physicians are taking more active role in ---- 1114
—— guide available at S.M.S. ---- 179
TUBERCULOSIS among mentally ill ---- 54

U. S. PUBLIC HEALTH, spending climbs ---- 1380
U. W. MEDICAL CENTER to be surveyed ---- 571

WAUSAU LOAN FIRM pays high tribute to M.D.'s 180
WHITE, W. C., named special aide to A.M.A. task force ---- 1023
W.I.A.A. makes report on football face masks -- 1376
WILL AND TESTAMENT, corporate executor recommended in executing ---- 910
—— counsel's advice should be sought in making 176
WISCONSIN BOARD OF MEDICAL EXAMINERS urges physicians to file registration ---- 1239
WISCONSIN HEART ASSOCIATION to meet in June 446
WISCONSIN MEDICAL ASSISTANTS SOCIETY meeting 309, 572
—— Alice Budny named recording secretary --- 1377
—— Miss Holtshopple installed as president ---- 1239
—— Miss Holtshopple named president-elect ---- 758
—— outline projects ---- 911
—— set up job placement plan ---- 1375
WISCONSIN PHYSICIANS SERVICE reports claims paid ---- 1237
WISCONSIN PUBLIC HEALTH COUNCIL meeting a big success ---- 753
WISCONSIN TRUDEAU SOCIETY, speakers' bureau will schedule speakers for county medical societies ---- 1114
WOMAN'S AUXILIARY names Mrs. Baumann president-elect ---- 652
WORLD MEDICAL ASSOCIATION invites members --- 913
—— Names new committee ---- 1242
—— Picks medical sign ---- 1238

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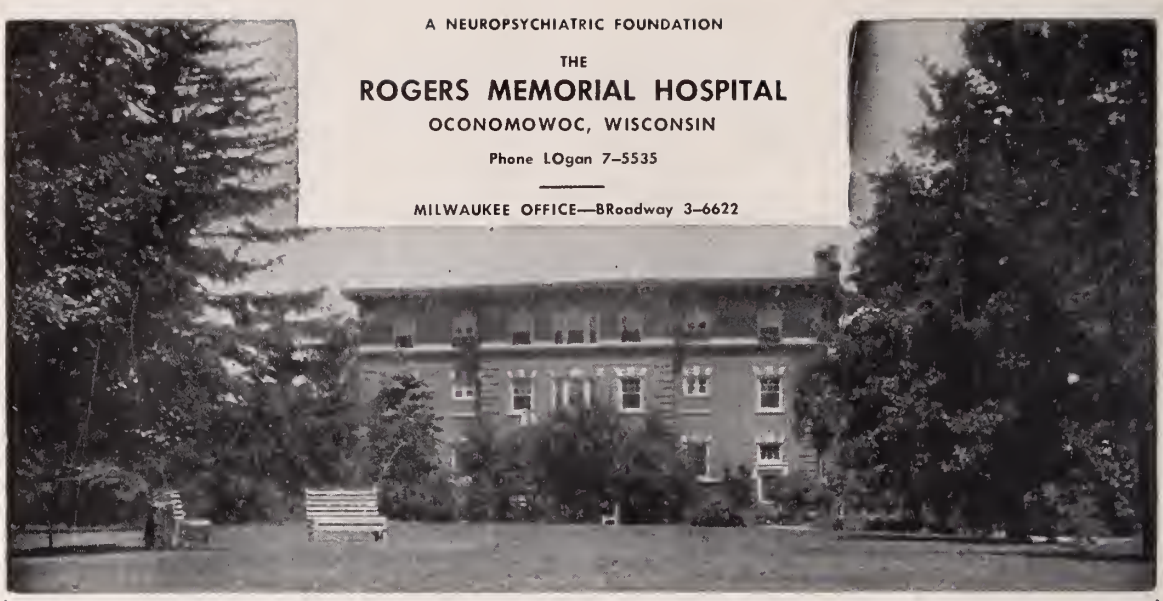

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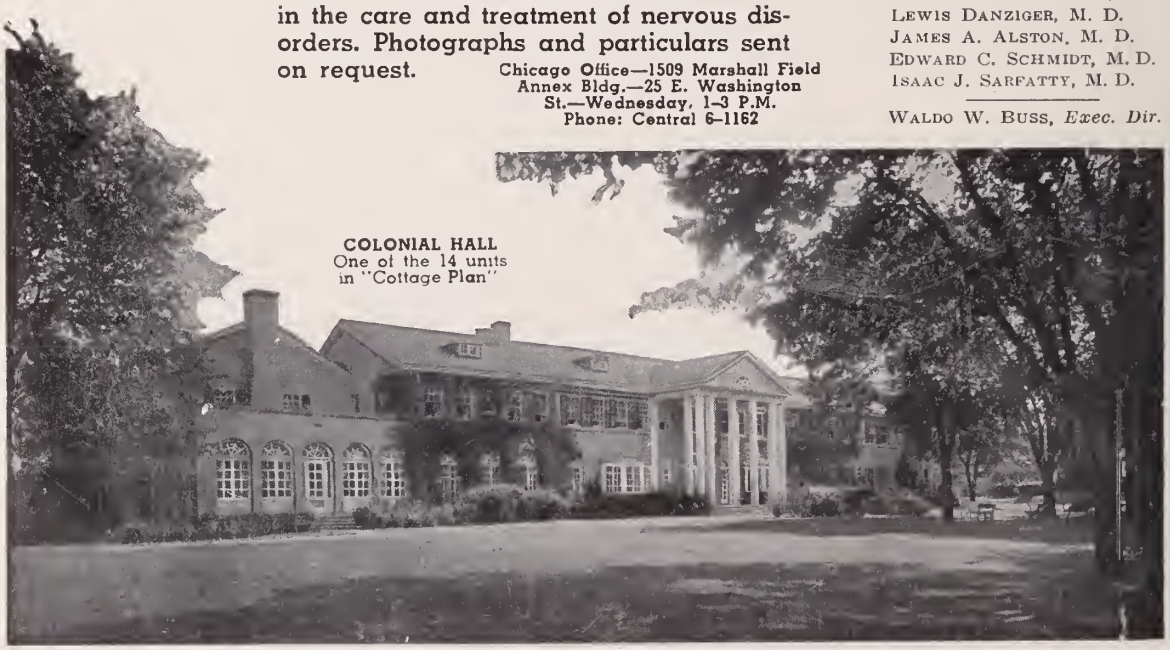

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